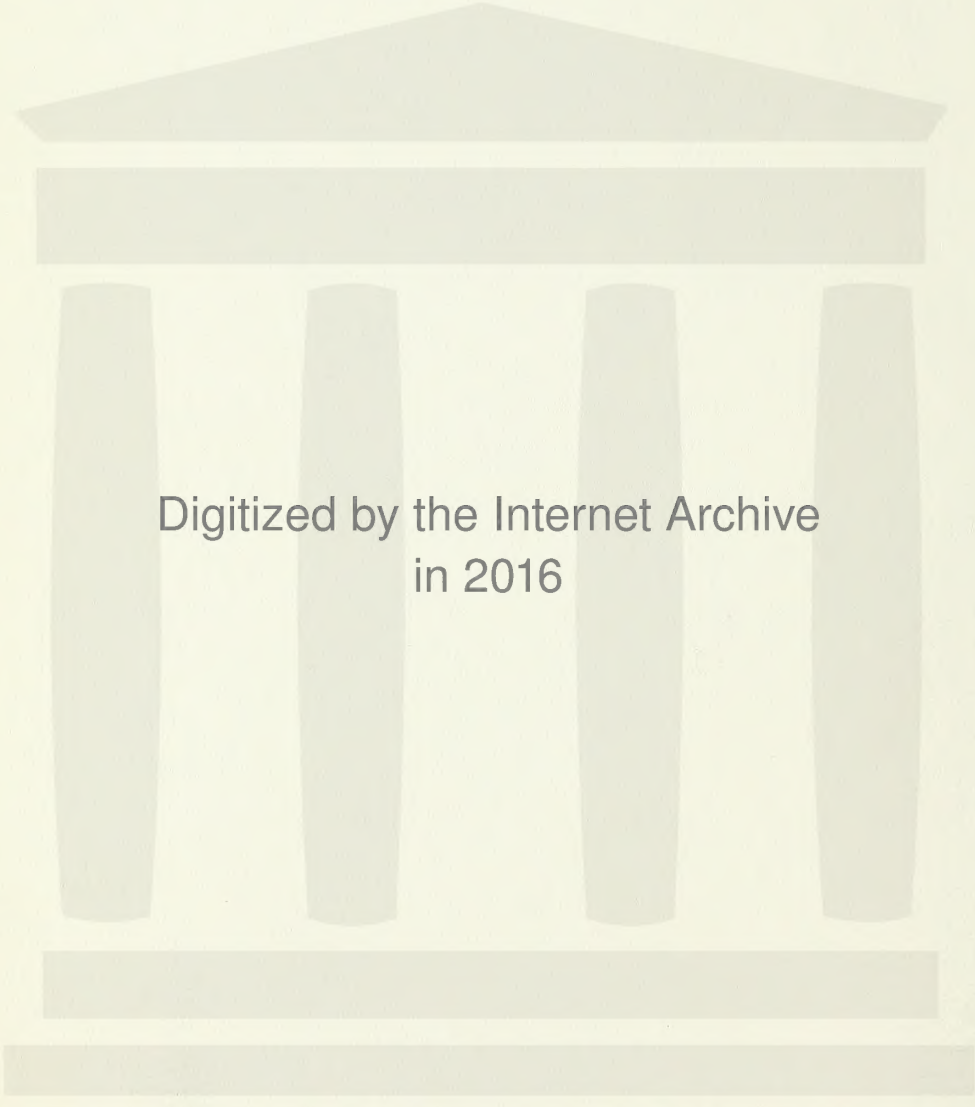
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Illinois Medical Journal

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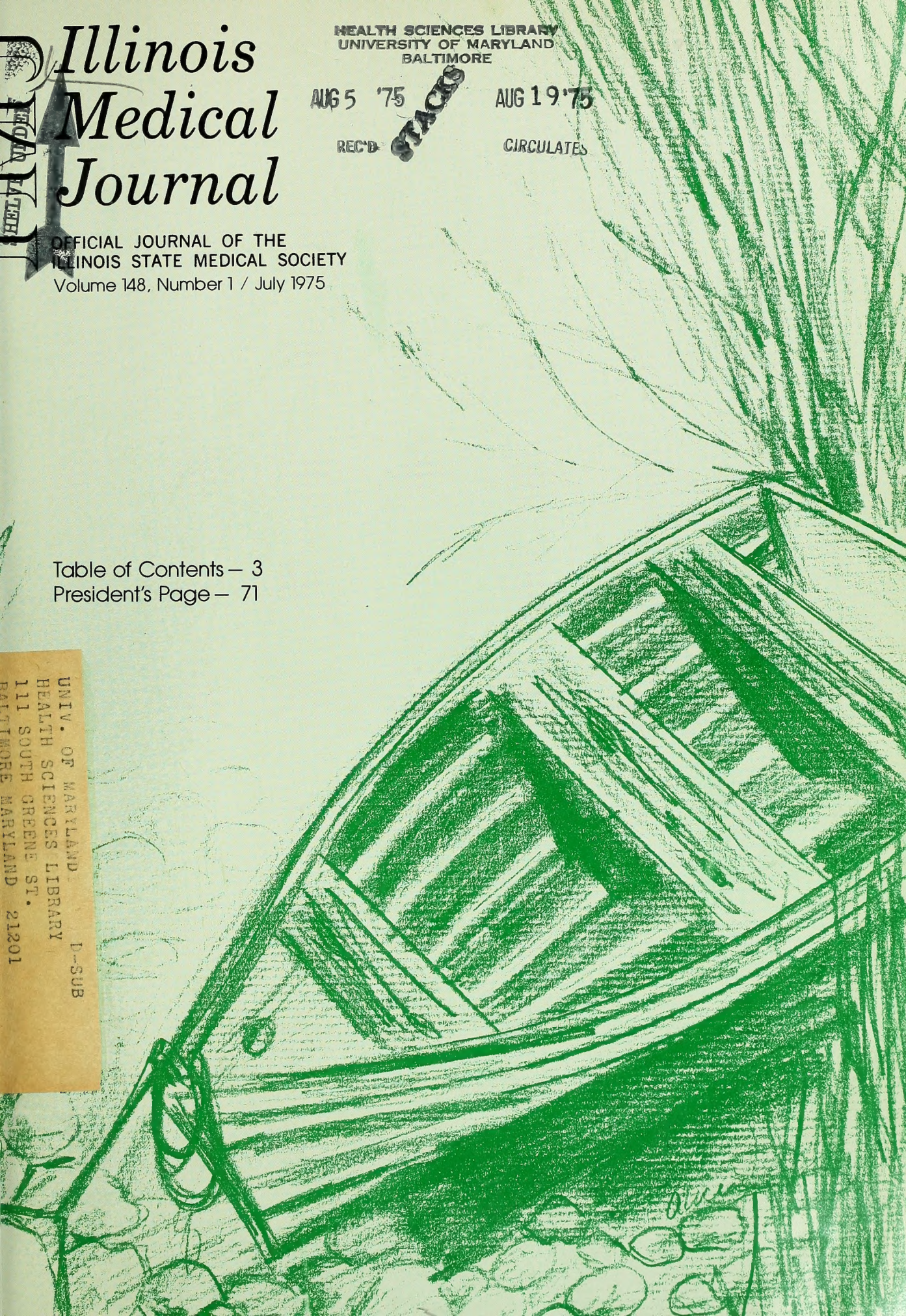
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OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY
Volume 148, Number 1 / July 1975

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BLUE SHIELD REPORT FOR Illinois Physicians

State Employes' Program Renewed with Blue Cross—Blue Shield

The Illinois Blue Cross-Blue Shield Plans will continue to administer the health care program of more than 120,000 State of Illinois employes and their dependents through June 30, 1976. Employes will be covered under the same broad scope of benefits they now have.

During the first contract year from July 1, 1973 through June 30, 1974, nearly 11½ million dollars in benefits were paid for professional services. For a portion of the latest fiscal year, July 1, 1974-April 30, 1975, benefit payments totaled approximately 7½ million dollars. Two special departments in the Chicago and Springfield offices have been handling details of the program. Our Claims Centers will provide faster payments when these procedures are followed:

1. In completing the Blue Shield Physician's Service Report form for a State of Illinois employe or dependent, please use the Illinois Employes Group Insurance Program number 42500, and **the employe's Social Security number.** Do not use the patient's Social Security number unless the patient **is the employe.** To assure proper identification, ask the **patient to present his Blue Shield State of Illinois Group Insurance Identification Card.** The card will show the proper employe's Social Security number. If he does not have a card, please obtain this information before submitting the claim.

2. If you receive a "State of Illinois Department" inquiry form from Blue Shield with a Physician's Service Report attached, enter the Social Security number of the state employe on the form to which the billing refers. Please do not use the physician's Social Security number, nor the patient's (unless the patient is the employe). This will delay payment of the claim until the necessary employee Social Security number is received for identification.

3. There are **no special forms or service reports** to submit for the State of Illinois program. Please use the current Blue Shield Physician's Service Report form in submitting a claim.

Program Summary

Payment of employe claims is made on a Usual and Customary fee basis. The program incorporates co-insurance and deductible amounts at various levels. Options to cover dependents are provided at the same or reduced levels as employes and include the High Option Plan IIA; Low Option Plan IIB and IIC. Although the scope of benefit coverage is the same, payment levels are reduced, deductibles are increased and maximum payments lowered depending on the premium level of the plan selected by the employe.

Benefits of the High Option Plan II are summarized below:

PHYSICIANS' SERVICES:

- In-hospital professional services, including surgery, surgical assistance, anesthesia, care of fracture and complete dislocations;
- In-hospital medical care—365 days—including necessary consultations, intensive care, concurrent care, psychotherapy, inhalation therapy;
- Maternity care and obstetrical services;
- Home or office visits when related to an illness or injury that required hospitalization, up to a maximum of $100 per person per contract year. Visits must be made within 90 days following hospital confinement.

(The above services are payable at 80% Usual and Customary for expenses up to $1,000; 90% U & C for the next $2,000 of expenses; 100% U & C for expenses over $3,000).

- Emergency medical and accident care if treated within 72 hours. Coverage is 100% U & C with no limitation.
- Outpatient surgery and diagnostic services at 100% U & C to a maximum of $200 per month and $600 per year, per person;
- Routine home or office visits are **not covered** until $200 for such charges has been reached for an individual in the contract year. Coverage then is at 50% U & C charges;
- Outpatient mental and nervous care are in

(Continued on following page)

benefit at 50% U & C, not to exceed payment of $25 per day;

• Obstetrical benefits include single female employes and female dependents. Early OB and terminal OB are in benefit with coverage for delivery providing conception occurred while the person was covered. Normal newborn care is covered.

• Prescription drugs are covered when such expenses are incurred for treatment outside the hospital. There is a deductible of $50 per person per contract year. Payment is made according to the following schedule: From $50-$1,000 per person, per year the plan pays 80%; $1,000-$3,000, 90% and for expenses over $3,000 per person, per year payment is 100% of expenses. Charges must be submitted on the Medical Expense Benefit form for payment.

MEDICAL EXPENSES:

Under medical expense coverage the following co-insurance variables apply:

1) 80% U & C charges for expenses up to $5,000; 2) 90% U & C for the next $5,000; 3) 100% U & C for expenses over $10,000.

A deductible of $50 per cause applies. There is a coordination of benefits provision throughout the entire program.

SUPPLEMENT TO MEDICARE:

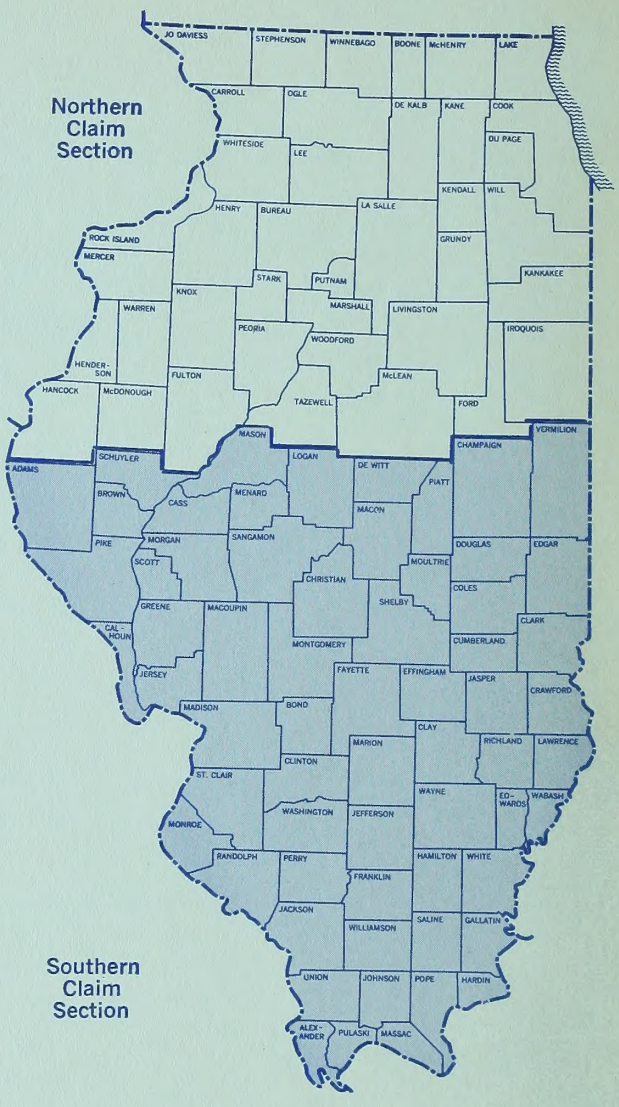
Benefits will be paid up to the maximum prescribed for this program and for any of the dependent option plans selected, less the amount paid by Medicare Part A and B. Blue Shield requires an Explanation of Medicare Benefits (EOMB) to pay benefits.

Send Claims to Proper Claims Center

For convenience in filing State of Illinois employe claims and to speed payments, two special Claims Centers serve the program exclusively. Please send them to the appropriate Claims Center.

Claims from the northern portion of the state including Cook and the counties south to Hancock, McDonough, Fulton, Tazewell, McLean, Ford and Iroquois should be mailed to the Chicago Claims Center, addressed to the Blue Shield Plan, 233 North Michigan Ave., State of Illinois Department, 21st floor, Chicago, Illinois 60601.

Physicians submitting claims in downstate areas below the counties dividing the state into the northern and southern Claim sections should send them to the Springfield Claims Center, addressed to the Blue Shield Plan, 525 West Jefferson Street, Suite 207, Springfield, Illinois 62702. (See map showing geographic divisions).



ASK BLUE SHIELD . . . ABOUT MEDICARE

Concurrent Medical Care

Part B Medicare regulations state that no payment can be made for medical or surgical services or for supplies which are not considered "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member."

Medicare benefits *are* provided for concurrent care when the medical necessity exists. This could occur when the patient is seriously ill and the special skills of two or more physicians are required on a continuing basis. Examples would be for a patient with a serious heart disease who undergoes major surgery, a patient who develops a pulmonary embolism or pneumonia during a postoperative period, or the cancer patient undergoing radiotherapy who develops cardiac or other medical or surgical problems.

Concurrent care should not be confused with continuing care by a consultant. When a consultant physician assumes the continuing care of a patient he becomes the attending physician, at least for that illness or portion of the illness that is mutually agreed upon by the original attending physician and the consulting physician. In this situation, Medicare benefits are available only for one physician at a time.

Benefits are available for concurrent care only when the medical need is clearly stated either in the diagnoses or by separate statement from the attending physician.

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Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

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Clinics for Crippled Children Listed for August

Twenty-three clinics for Illinois' physically handicapped children have been scheduled for August by the University of Illinois, Division of Services for Crippled Children. The Division will count sixteen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical, social and nursing services. There will be six special clinics for children with cardiac conditions, and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

August 5 E. St. Louis, Christian Welfare Hospital
August 6 Hinsdale, Hinsdale Sanitarium
August 7 Sterling, Sterling Community Hospital
August 7 Litcheld, St. Francis Hospital
August 7 Lake County Cardiac, Victory Memorial Hospital
August 8 Chicago Heights Cardiac, St. James Hospital
August 11 Peoria Cardiac, St. Francis Children's Hospital
August 12 Belleville, St. Elizabeth's Hospital
August 12 Peoria, St. Francis Children's Hospital
August 13 Champaign-Urbana, McKinley Hospital
August 14 Springfield, St. John's Hospital
August 14 Kankakee, St. Mary's Hospital
August 19 E. St. Louis, Christian Welfare Hospital
August 19 Rock Island, Moline Public Hospital
August 20 Chicago Heights, St. James Hospital
August 21 Bloomington, Mennonite Hospital
August 21 Elmhurst Cardiac, Memorial Hospital of Du-Page County
August 22 Chicago Heights Cardiac, St. James Hospital
August 22 Evanston, St. Francis Hospital
August 25 Peoria Cardiac, St. Francis Children's Hospital
August 26 Peoria, St. Francis Children's Hospital
August 27 Springfield Pediatric Neurology, Diocesan Center
August 27 Aurora, St. Joseph Mercy Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospital, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

Editorials

Coronary Bypass Surgery

A retired physician had spent a leisurely day in the country relaxing and enjoying himself. After dinner, he was in his room sitting quietly on the edge of his bed when he was suddenly seized with a severe sense of pressure beneath the sternum radiating down both arms. He was given codeine and propranolol, but for 10 minutes, the pain became steadily worse and then began to subside. Someone drove him to the hospital, but on the way, he felt so well that he and his wife decided to go home.

He was free of pain the next day (Sunday) and on Monday consulted his physician who found minor changes on the electrocardiogram and advised hospitalization. That night, while in the hospital, he had another attack that was quite severe and more difficult to control. There were no changes in the electrocardiogram and all enzyme tests were within normal limits. The diagnosis was acute coronary insufficiency but no evidence of myocardial damage.

Coronary arteriography was done on the fourth day showing a 90 per cent obstruction of the main trunk of the left anterior descending coronary artery with good circulation distal to the stenosis. The other two arteries were mildly affected. A well-trained cardiac surgeon who does four to five heart operations a week advised immediate surgery. The obstructed vessel was bypassed with an aorto-coronary venous graft. Our colleague made a complete recovery and his angina has not recurred.

This is an example of the significant improvement that has been made in our approach to certain problems associated with coronary heart disease. This man was an ideal candidate for bypass surgery. Only one coronary artery (often dubbed the sudden death artery) was 90 per cent obstructed and his myocardium was not damaged. Obviously, he is ahead of the game if the bypass remains open and if the arteriosclerotic process in his other vessels can be delayed by avoiding well-known risk factors. He was also lucky to have a surgeon who is familiar with all phases of the procedure.

Most authorities now agree that in properly selected patients with coronary artery stenosis, the saphenous vein bypass operation often improves the blood supply to the myocardium, immediately eliminates the angina, and strengthens the myocardial contraction. Candidates for this type of surgery should have severe obstruction but there should be no significant obstruction beyond the proposed bypass. In the hands of capable surgeons, the mortality rate is less than two per cent. It obviously increases with or without surgery for single, double, or triple artery disease.

Unfortunately, we lack an adequate number of well-trained physicians to perform and interpret cine coronary angiography and surgeons to carry out the procedure. And, yet, we have selective coronary arteriography to thank for the surgical approach to this problem and improvements are constantly being reported. Arteriography also has been most useful in excluding the presence of coronary atherosclerosis in a large number of patients whose chest pain is due to other causes.

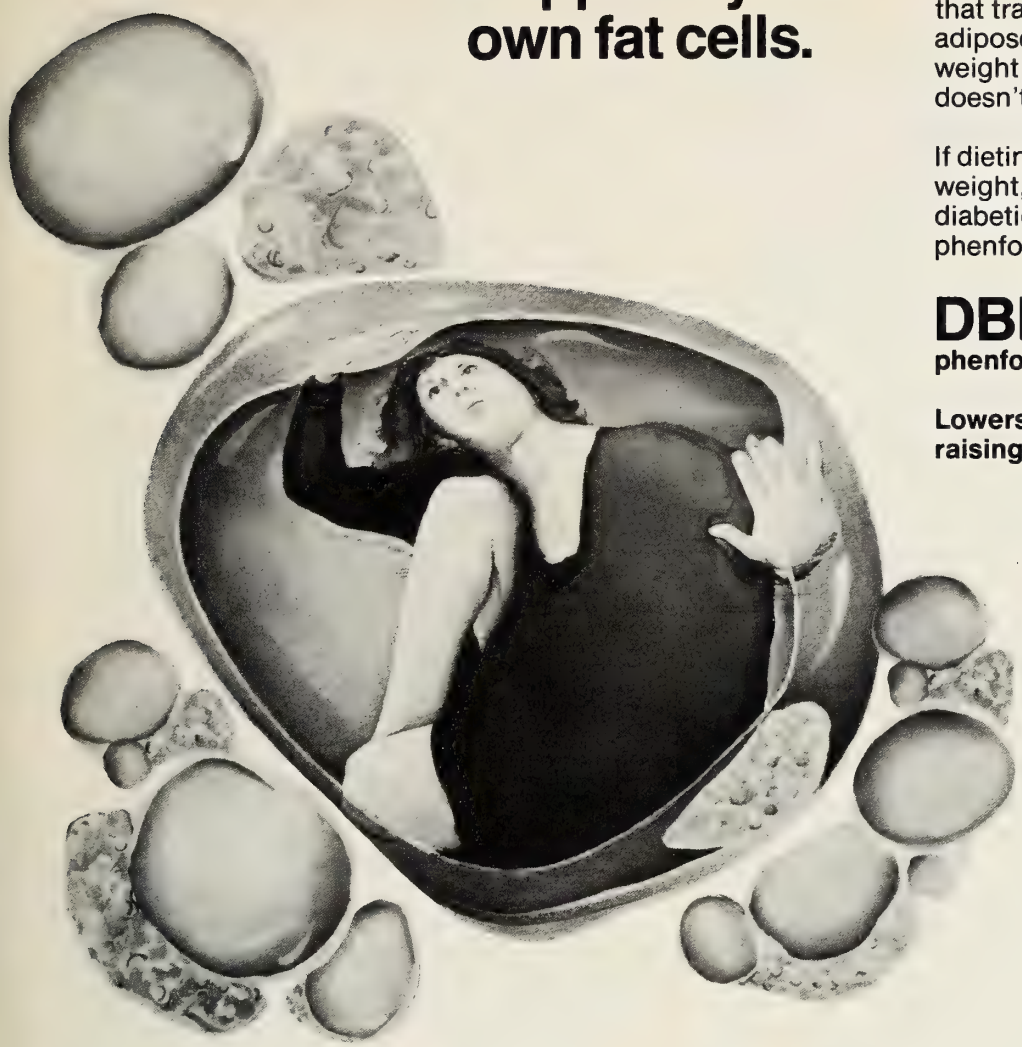
Coronary bypass will not improve the circulation in an old infarction. However, coronary arteriography may be done from 4 to 6 weeks from the onset of an infarction to determine the condition of the coronary arteries.

The alternative to bypass graft surgery for angina is the conservative treatment which is almost as successful in cooperative patients. The latter includes the omission of smoking, control of hypertension, and weight reduction. Keeping the cholesterol level at normal limits may be helpful, but it is more important to educate the patient regarding the factors that aggravate and precipitate the distress. These include emotional stress and lifestyle. The mainstay of treatment is nitroglycerin and sublingual nitrites combined with beta-blocking drugs such as propranolol (Inderal). A properly designed program of exercise not only reduces the frequency and severity of anginal attacks, but it also increases the work capacity and enhances the sense of well-being.

Editor
T. R. Van Dellen, M.D.

The overweight diabetic...

trapped by her own fat cells.



If only she would diet, her blood sugar might come down. Her high levels of blood insulin might come down, too. This may be important in the overweight diabetic since insulin is the "storage hormone" that transports glucose into adipose tissue. Maybe the overweight diabetic needs a drug that doesn't stimulate insulin secretion.

If dieting doesn't work in the overweight, nonketotic, adult-onset diabetic, consider adding DBI-TD,® phenformin HCl.

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Indications: Stable, adult diabetes mellitus; sulfonylurea failures, primary and secondary; adjunct to insulin therapy of unstable diabetes mellitus.
Contraindications: Diabetes mellitus that can be regulated by diet alone; hypersensitivity to phenformin; renal disease with impaired renal function; a history of lactic acidosis; alcoholism; juvenile diabetes mellitus that is uncomplicated and well regulated on insulin; acute complications of diabetes mellitus (metabolic acidosis, coma, infection, gangrene); during or immediately after surgery where insulin is indispensable; severe hepatic disease; cardiovascular collapse (shock); after disease states associated with hypoxemia.
Warnings: Lactic Acidosis: There have been numerous reports of lactic acidosis in patients receiving phenformin. This is an often fatal metabolic acidosis, characterized by elevated lactate levels, an increased lactate-to-pyruvate ratio, and decreased blood pH. In most cases, azotemia ranging from mild to severe was present. This may have been the result of dehydration. In some patients who developed lactic acidosis, serum creatinine was later within normal limits when the patients were properly hydrated. Observe the following specific warnings:
a. Impairment of renal function increases the risk of lactic acidosis. Perform renal function tests, such as serum creatinine, prior to phenformin therapy and annually thereafter. Phenformin is contraindicated in patients with impaired renal function.
b. Cardiovascular collapse (shock), congestive heart failure, acute myocardial infarction, and other conditions characterized by hypoxemia have been associated with lactic acidosis and also may cause prerenal azotemia. Use of phenformin in patients likely to develop such conditions must be carefully considered. Discontinue phenformin promptly when such events occur.
c. Gastrointestinal disturbances are the most common adverse reactions of phenformin therapy and must be distinguished from the prodrome of lactic acidosis. Anorexia and mild nausea are not uncommon side effects, particularly upon initiation of therapy.
Nausea, vomiting, malaise, or abdominal pain may herald the onset of lactic acidosis. Instruct the patient to notify the physician immediately should any of these symptoms or hyperventilation occur. Withdraw phenformin until the situation is clarified by determination of electrolytes, and, if necessary, pH, blood sugar, ketones, lactate, and pyruvate.
d. Lactic acidosis has a significant mortality. When suspected, discontinue phenformin and institute bicarbonate infusions and other appropriate therapy, even before the results of lactate determinations are available. It should be suspected in the presence of a metabolic acidosis in any diabetic patient lacking evidence of ketoacidosis (ketonuria and ketonemia) and not intoxicated with methanol or salicylates, or not in uremic acidosis.
e. Use special caution after initiation of phenformin therapy, after increase of drug dosage, and in circumstances that may cause dehydration leading to impaired renal function.
f. Warn patients against using alcohol in excess while receiving phenformin, since ethanol and phenformin potentiate the tendency of each to cause an elevation of blood lactate levels.
Pregnancy: Use during pregnancy is to be avoided.
Precautions: Starvation Ketosis: This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria, in spite of relatively normal blood sugar with little or no urinary sugar. This may result from excessive phenformin therapy or insufficient carbohydrate intake.
"Destabilization" of Previously Controlled Diabetic: When laboratory abnormalities or clinical illness develop, evaluate electrolytes, pH, lactate, pyruvate, and blood and urine ketones for evidence of ketoacidosis or lactic acidosis. With either form, withdraw phenformin and institute corrective therapy.
Hypoglycemia: Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.
Adverse Reactions: Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake. (B) 98-146-103-H (8/74)
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Hints for Behavior

Encouraging communication by manner, gesture, or words that do not specify the specific information sought is called facilitation. It represents a greater use of authority than silence but still exerts a low degree of control. Since a completely impassive silence on the part of the interviewer is relatively uncommon, silence and facilitation tend to go hand in hand. An interested, attentive manner is, of course, facilitating. Any change of facial expression or posture displaying greater interest or attention is a facilitation. A common mode of facilitation is the nod of the head, conveying, "I'm listening," "I understand what you're saying," or "Go on." This message is encouraging to the patient, but can be overused. Inexperienced interviewers frequently relieve their own tension during the interview with what might be called the head-nodding syndrome. The clinician also should take pains not to nod the head for facilitating purposes when the patient has been expressing a strong opinion. In some instances, such action may be mistaken for approval or agreement.

A similar message is conveyed to the patient with an occasional "Mmm-mmm' or by postural shifts toward the patient or into a position of greater alertness. The doctor may also interject short words or phrases, such as "Yes," or "I see," without interrupting the flow of the patient's narrative. (Allen J. Enelow and Leta McKinney Adler, "How to interview your patients," *Practical Psychology for Physicians* [Nov/Dec] 1974, pgs. 59-70.)

Why I Joined a Union

What about the climate of practice today? Here is where my biggest grievances lay and where I found the greatest source of misgivings for the future. It isn't nearly as much fun for me to practice medicine now as it was ten or even five years ago. My "job satisfaction" has definitely declined. Though I haven't had any major personal confrontations, I often feel whipsawed and manipulated by the competing demands of third parties: consumers, government, the insurance industry, and even the universities. What I've seen has convinced me that the rules of the game are no longer honest. The competition for power among third parties has led to increasingly painful dilemmas in everyday practice—dilemmas that can't be handled simply by working harder, getting more involved, or showing more good will. (Philip R. Alper: Why I Joined a Union. *Prism* (May) 1974, pgs. 26-28, 65 and 71.)

PROLOID® (thyroglobulin)

Caution: Federal law prohibits dispensing without prescription.

Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of T_4 and T_3 in Proloid (thyroglobulin) is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.

Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.

Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, $T_3{}^{131}I$ resin sponge uptake, $T_3{}^{131}I$ red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Instructions for Use. The following conversion table lists the approximate equivalents of other thyroid preparations to Proloid (thyroglobulin) when changing medication from desiccated thyroid, T_4 (sodium levothyroxine), T_3 (sodium liothyronine), or T_4/T_3 (liotrix).

CONVERSION TABLE

Dose of Proloid (thyroglobulin)	Dose of Desiccated Thyroid	Dose of T_4 (sodium levothyroxine)	Dose of T_3 (sodium liothyronine)	Dose of liotrix (T_4/T_3)
1 grain	1 grain	0.1 mg	25 mcg	#1 (60 mcg/15 mcg)
2 grains	2 grains	0.2 mg	50 mcg	#2 (120 mcg/30 mcg)
3 grains	3 grains	0.3 mg	75 mcg	#3 (180 mcg/45 mcg)
4 grains	4 grains	0.4 mg	100 mcg	
5 grains	5 grains	0.5 mg	125 mcg	

In changing from Thyroid USP to Proloid (thyroglobulin), substitute the equivalent dose of Proloid (thyroglobulin). Each patient may still require fine adjustment of dosage because the equivalents are only estimates.

Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

Supplied. ¼ grain tablets in bottles of 100 (N 0047-0250-51) and 1000 (N 0047-0250-60); ½ grain tablets in bottles of 100 (N 0047-0251-51) and 1000 (N 0047-0251-60); scored 1 grain tablets in bottles of 100 (N 0047-0252-51) and 1000 (N 0047-0252-60); 1½ grain tablets in bottles of 100 (N 0047-0253-51) and 1000 (N 0047-0253-60); scored 2 grain tablets in bottles of 100 (N 0047-0257-51); 3 grain tablets in bottles of 100 (N 0047-0254-51) and 1000 (N 0047-0254-60); scored 5 grain tablets in bottles of 100 (N 0047-0255-51) and 1000 (N 0047-0255-60). Full information is available on request. P-GP-51 4/c

WARNER/CHILCOTT
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Poison ivy and other severe allergic states intractable to adequate trials of conventional treatment will often respond to a short, intensive, adjunctive course of Medrol. Medrol Dosepak is designed to provide a tapered, six-day course of methylprednisolone tablets.

On occasion, a six-day course of Medrol therapy may not be sufficient and therapy may need to be extended. If there is continued contact with the sensitizing agent, corticosteroids will not completely suppress the inflammatory response. A further caution: If lesions become infected during Medrol therapy, it should be remembered that steroids may decrease resistance to infection and hinder the body's ability to localize an infection.

MEDROL COMPRESSED TABLETS—2, 4 & 16 MG
(METHYLPREDNISOLONE TABLETS, N.F., UPJOHN)

DESCRIPTION AND ACTIONS: Medrol (methylprednisolone) is a synthetic glucocorticoid with potent anti-inflammatory effects. It is readily absorbed from the GI tract. Glucocorticoids cause profound and varied metabolic effects and modify the body's immune responses to diverse stimuli.

INDICATIONS: 1. **Endocrine Disorders:** Primary or secondary adrenocortical insufficiency (hydrocortisone or cortisone is the first choice; synthetic analogs may be used in conjunction with mineralocorticoids where applicable; in infancy, mineralocorticoid supplementation is of particular importance). Congenital adrenal hyperplasia; nonsuppurative thyroiditis; hypercalcemia associated with cancer. 2. **Rheumatic Disorders:** As adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in: psoriatic arthritis; rheumatoid arthritis (selected cases may require low-dose maintenance therapy); ankylosing spondylitis; acute and subacute bursitis; acute nonspecific tenosynovitis; acute gouty arthritis. 3. **Collagen Diseases:** During an exacerbation or as maintenance therapy in selected cases of—Systemic lupus erythematosus; acute rheumatic carditis. 4. **Dermatologic Diseases:** Pemphigus; bullous dermatitis herpetiformis; severe erythema multiforme (Stevens-Johnson syndrome); exfoliative dermatitis; mycosis fungoides; severe psoriasis. 5. **Allergic States:** Control of severe or incapacitating allergic conditions intractable to adequate trials of conventional treatment: Seasonal or perennial allergic rhinitis; bronchial asthma; contact dermatitis; atopic dermatitis; serum sickness. 6. **Ophthalmic Diseases:** Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as—allergic corneal marginal ulcers; herpes zoster ophthalmicus; anterior segment inflammation; diffuse posterior uveitis and choroiditis; sympathetic ophthalmia; allergic conjunctivitis; keratitis; chorioretinitis; optic neuritis; iritis and iridocyclitis. 7. **Respiratory Diseases:** Symptomatic sarcoidosis; Loeffler's syndrome not manageable by other means; berylliosis; fulminating or disseminated pulmonary tuberculosis when concurrently accompanied by appropriate antituberculous chemotherapy. 8. **Hematologic Disorders:** Idiopathic and secondary thrombocytopenia in adults; acquired (autoimmune) hemolytic anemia; erythroblastopenia (RBC anemia); congenital (erythroid) hyperplastic anemia. 9. **Neoplastic Diseases:** For palliative management of: leukemias and lymphomas in adults; acute leukemia of childhood. 10. **Edematous States:** To induce a diuresis or remission of proteinuria in the nephrotic syndrome, without uremia, of the idiopathic type or that due to lupus erythematosus. 11. **Miscellaneous:** Tuberculous meningitis with subarachnoid block or impending block when concurrently accompanied by appropriate antituberculous chemotherapy. Systemic dermatomyositis (polymyositis).

CONTRAINDICATIONS: Systemic fungal infections.

WARNINGS: In patients on corticosteroid therapy subjected to unusual stress, increased dosage of rapidly acting corticosteroids before, during, and after the stressful situation is indicated.

Corticosteroids may mask some signs of infection and new infections may appear during their use. There may also be decreased resistance and inability to localize infection. Prolonged use may enhance the establishment of secondary ocular infections due to fungi or viruses.

Since adequate human reproductive studies have not been done, the use in pregnancy, nursing mothers or women of childbearing potential requires that the possible benefits be weighed against the potential hazards to the mother and the embryo or fetus. Infants should be observed for signs of hypoadrenalism.

Average and large doses of hydrocortisone or cortisone can cause elevation of blood pressure, salt and water retention, and increased excretion of potassium. These effects are less likely to occur with the synthetic derivatives except when used in large doses. Dietary salt restriction and potassium supplementation may be necessary. All corticosteroids increase calcium excretion.

While on corticosteroid therapy, patients should not be vaccinated against smallpox. Other immunization procedures should not be undertaken in patients who are on corticosteroids, especially on high dose, because of possible hazards of neurological complications and a lack of antibody response.

The use of corticosteroids in active tuberculosis should be restricted to those cases of fulminating or disseminated tuberculosis in which the corticosteroid is used for the management of the disease in conjunction with an appropriate antituberculous regimen.

If corticosteroids are indicated in patients with latent tuberculosis or tuberculin reactivity, close observation is necessary as reactivation of the disease may occur. During prolonged corticosteroid therapy, these patients should receive chemoprophylaxis.

PRECAUTIONS: Hormone therapy is an adjunct to, and not a replacement for, conventional therapy.

Dosage should be individualized according to the severity of the disease and the response of the patient. As soon as a satisfactory clinical response is obtained, the daily dose should be reduced, either to termination of treatment or to the minimal effective maintenance dose level. The lowest possible dose should be used and when reduction in dosage is possible, the reduction should be gradual if the drug has been administered for more than a few days. If a period of spontaneous remission occurs in a chronic condition, treatment should be discontinued.

Drug-induced secondary adrenocortical insufficiency may be minimized by gradual reduction of dosage. This type of relative insufficiency may persist for months after discontinuation of therapy; therefore, in any situation of stress occurring during that period, hormone therapy should be reinstituted. Since mineralocorticoid secretion may be impaired, salt and/or a mineralocorticoid should be administered concurrently.

There is an enhanced effect of corticosteroids on patients with hypothyroidism and in those with cirrhosis.

Corticosteroids should be used cautiously in patients with ocular herpes simplex because of possible corneal perforation.

Psychic derangements may appear or existing emotional instability or psychotic tendencies may be aggravated by corticosteroids.

Aspirin should be used cautiously in conjunction with corticosteroids in hypoprothrombinemia..

Steroids should be used with caution in nonspecific ulcerative colitis, if there is a probability of impending perforation, abscess or other pyogenic infection; diverticulitis; fresh intestinal anastomoses; active or latent peptic ulcer; renal insufficiency; hypertension; osteoporosis; and myasthenia gravis.

Growth and development of infants and children on prolonged corticosteroid therapy should be carefully observed.

Blood pressure, body weight, routine laboratory studies, including 2-hour postprandial blood glucose and serum potassium, and a chest X-ray should be obtained at regular intervals during prolonged therapy. Upper GI X-rays are desirable in patients with known or suspected peptic ulcer disease.

ADVERSE REACTIONS: Fluid and Electrolyte Disturbances. Sodium retention; fluid retention; congestive heart failure in susceptible patients; potassium loss; hypokalemic alkalosis; hypertension. **Musculoskeletal.** Muscle weakness; steroid myopathy; loss of muscle mass; osteoporosis; vertebral compression fractures; aseptic necrosis of femoral and humeral heads; pathologic fracture of long bones. **Gastrointestinal.** Peptic ulcer with possible perforation and hemorrhage; pancreatitis; abdominal distention; ulcerative esophagitis. **Dermatologic.** Impaired wound healing; thin fragile skin; petechiae and ecchymoses; facial erythema; increased sweating. May suppress reactions to skin tests. **Neurological.** Increased intracranial pressure with papilledema (pseudotumor cerebri) usually after treatment. Convulsions; vertigo; headache. **Endocrine.** Development of Cushingoid state; suppression of growth in children; secondary adrenocortical and pituitary unresponsiveness, particularly in times of stress, as in trauma, surgery or illness; menstrual irregularities; decreased carbohydrate tolerance; manifestations of latent diabetes mellitus; increased requirements for insulin or oral hypoglycemic agents in diabetics. **Ophthalmic.** Posterior subcapsular cataracts; increased intraocular pressure; glaucoma; exophthalmos. **Metabolic.** Negative nitrogen balance due to protein catabolism.

DOSAGE AND ADMINISTRATION: The initial dosage may vary from 4 to 48 mg per day. **Requirements are variable and must be individualized on the basis of the disease under treatment and the response of the patient.** The proper maintenance dosage should be determined by decreasing the initial dosage in small decrements at appropriate time intervals until the lowest dosage which will maintain an adequate clinical response is reached. If after long-term therapy the drug is to be stopped, it is recommended that it be withdrawn gradually rather than abruptly.

ALTERNATE-DAY THERAPY (ADT): ADT is a corticosteroid dosing regimen in which twice the usual daily dose of corticoid is administered every other morning. The purpose of this mode of therapy is to provide the patient requiring long-term pharmacologic dose treatment with the beneficial effects of corticoids while minimizing certain undesirable effects including pituitary-adrenal suppression, the Cushingoid state, corticoid withdrawal symptoms, and growth suppression in children.

Medrol (methylprednisolone) or other short-acting (producing adrenocortical suppression for 1¼ to 1½ days following a single dose) corticoids are recommended for ADT. Complete control of symptoms will not be possible in all patients. When considering this mode of therapy, keep in mind the basic principles and indications for corticosteroid therapy. The benefits of ADT should not encourage the indiscriminate use of steroids.

SUPPLIED: 2 mg—in bottles of 30 and 100 scored tablets; **4 mg**—in bottles of 30, 100 and 500 scored tablets and in 21 scored tablet Dosepak™ ; **16 mg**—in bottles of 50 scored tablets and in 14 scored tablet ADT Pak® (formerly Alternate Daypak®).

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Abstracts of Board Actions

May 17-18, 1975 **Chicago**

New Trustees Seated

In addition to those regularly elected by the House of Delegates in April, two additional trustees were seated at the Board of Trustees meeting. Drs. P. John Seward, Rockford, representing the new 1-A District (nine counties in northwestern Illinois), and Joseph C. Sherrick, Chicago, representing District 3, were nominated by ISMS delegates from their respective areas and formally elected by the Board in accordance with an April 5 House of Delegates action.

Surcharges Approved for Professional Liability Insurance

A system of surcharges, ranging from 25 to 200% of premium, will be instituted under the ISMS professional liability insurance program. In an effort to relate premiums to the risk presented by certain individuals, the Board authorized a surcharge plan to cover physicians engaged in questionable practice as determined by ISMS peer review procedures.

In a related action, the Board authorized the Executive Committee to handle all matters connected with pending legislation sponsored by ISMS to alleviate the malpractice insurance crisis. It was noted that more than 350 doctors had rallied in Springfield May 14 in support of such bills.

Sun-Times Newspaper Series

The Board directed legal counsel to draft a letter to the Chicago Sun-Times requesting retraction of a recently published statement that ISMS "once had secret arrangements with the state public aid department to suppress publicity on doctors caught cheating on Medicaid billings."

Podiatrists

The Board approved the following statement on the propriety of podiatrists prescribing anorectic and oral hypoglycemic drugs for their patients:

> "With concern for the welfare of patients, the Illinois State Medical Society has reviewed the law which permits podiatrists to treat medical and surgical problems of the feet. When those problems of the feet represent complications of systemic diseases, the podiatrist would be exceeding his capacity and training if he prescribes any medications which have any significant systemic effects. Local treatment of a foot complication of a systemic disorder is in keeping with the principles and practice of podiatry. However, a prescription that affects the underlying or causative systemic disease requires the skills of a physician licensed to practice medicine in all its branches and who has personally examined the patient."

Blue Shield Mental Health Report

Legal counsel has been directed to review a new mental health form used by Blue Shield. According to the Council on Mental Health and Addiction, the form appears to provide for diagnosis of mental illness by non-physicians.

Emergency Medical Services Award

Decatur Memorial and St. Mary's hospitals in Decatur have been selected to receive the first ISMS Emergency Medical services Award for their efforts during the 1974 railroad yard explosion and the tornado disaster which plagued their community.

Guidelines for Physician Directories

To help county societies in their development of local medical information for consumers, the Board approved a set of Physician Directory Guidelines, which will be distributed next month to all county medical societies. Cost of printing and distribution will be sought from the Educational and Scientific Foundation.

Surgeons Billing for Supervising Nurse Anesthetists

The Board referred to the Executive Committee a recommendation that ISMS oppose the practice of surgeons billing for supervising nurse anesthetists during operations. Meanwhile, legal council will develop an opinion on the legality of such policy statement for consideration by the Executive Committee.

Medicare Charge Data

The Board will explore legal steps by which the accuracy of methods used by Medicare fiscal intermediaries in computing physician's payments can be verified. The action followed a report of the Council on Economics and Peer Review that the Bureau of Health Insurance failed to provide ISMS with adequate documentation on the accuracy of prevailing fee data.

Peer Reviewing Non-ISMS Members

ISMS will accept peer review appeals involving non-member physicians who agree to cooperate with the procedures. Requests for appeal can come from patients, third party payors or any physician, following consideration at the local Society level. The Board will urge county medical societies to accept peer review requests from non-member physicians.

Drugs Recommended for Inclusion in Drug Manual

The Board approved the following drugs for inclusion in the IDPA Drug Manual: Moban, Vermox, Catapres, Antiminth, Calcimar, Cylert, Rorasul, Maalox Plus tablets and Maalox plus suspension. In a related action, the Board approved the adding of a general category of anti-neoplastic agents to the manual. The Board was also informed that June 1 is the target date for publication of a new drug manual.

Joint Annual Meeting

Drs. Allan Goslin, Jacob Reisch and J. M. Ingalls were appointed to the Joint Management Committee with instructions to explore the feasibility of continuing the combined ISMS annual convention and CMS clinical conference with some modification in format. The Joint Management Committee for the convention has tentatively scheduled the 1976 meeting for March 28-31 at the Conrad Hilton Hotel, Chicago.

Washington Roundup

The Board will hold its winter meeting in Washington, D.C., in connection with the 1976 Washington Roundup. Another weekend legislative retreat, similar to that held in September, 1974, at Chateau Louise, is being planned.

Legislation

The Board agreed to <u>support</u> the following legislation which is pending in the General Assembly:

HB 348, which calls for a $150,000 appropriation to the Council for Family Practice for ongoing operations expenses and a $750,000 appropriation to the council for grants to family practice residency programs.

HB 1369, which defines death for purposes of the Uniform Anatomical Gift Act to mean the irreversible cessation of total brain function according to the usual and customary standards of medicine.

HB 1569, as amended, and SB 495 (companion bills) to repeal the section of the School Code dealing with examination and innoculation of pupils and adds a new section.

HB 1593, if amended to provide for Senate confirmation of the Director of Comprehensive Health Planning within the Department of Public Health, which would become the health planning agency for the state under this bill.

HB 1964, if ISMS amendments become a part of this bill which would establish continuing education requirements for persons licensed under the Medical Practice Act.

HB 2054 and 2013, which were introduced for ISMS to create a State Council on Nutrition and appropriate $100,000 for its operation.

HB 2277, the hearing aid prescription bill which has been amended to require a

physician to examine a patient being issued a hearing aid on a prescription written by an audiologist.

SB 642, which reaffirms sections of the Controlled Substances Act that would otherwise expire this year.

SB 739, which allows physicians to delegate health tasks to physician assistants, consistent with the health and welfare of the patient, and includes an ISMS amendment that restricts the physician to one assistant and requires that assistant to work only in the area of specialty in which his employer is actively engaged.

SB 945, which requires the Department of Public Aid to provide the Legislative Advisory Commission with quarterly reports in writing covering certain categories of expenditures, case load statistics and report of fraud and abuse.

SB 946, which requires the Department of Public Aid to seek consultation with the Legislative Advisory Commission prior to effecting any changes in fees or other payments to dispensers of medical services.

SB 947, which requires the Department of Public Aid to establish rules regarding the dispensing of health services, and requires dispensers of medical services to maintain records to document the nature and extent of care provided.

SB 948, 949, 950, a series of bills concerning welfare fraud investigations now embodied in other legislation receiving ISMS support.

SB 1005, which abolishes the Medical Payment Fund under the Public Aid Code in order to allow payment of public aid bills in a fiscal year other than the one in which the appropriation was passed.

The Board agreed to <u>oppose</u> the following legislation pending in the General Assembly:

HB 871, which would require physicians who do laboratory work in their offices to pass a proficiency test annually. The Board would support a three-year study program in lieu of mandatory testing.

HB 1080, unless amended to prohibit direct payment to psychologists for patients not referred by physician. The bill basically requires health insurance policies to offer coverage for mental, emotional and nervous disorders, which ISMS favors.

HB 2387, which would expand the scope of chiropractic in Illinois.

HB 2608, which would significantly expand the scope of the nurse practitioner by deleting from the Nurse Practice Act the current exclusion, "acts of medical diagnosis or prescription of therapeutic corrective measures."

The Board referred the following bills to the Executive Committee:

HB 1262, which deals with the licensure of audiologists and is subject to unacceptable alterations prior to passage.

HB 1496, which would license and regulate ambulances and invalid coach services. The Board directed the Executive Committee to maintain close scrutiny over this bill, which has the potential of eliminating all ambulance service in rural areas of Illinois.

HB 1928, which broadens the definition of health maintenance organizations to include persons providing basic health care services.

HB 2406, amending the Cook County Hospitals Governing Commission Act to require the commission's budget submitted to the County Board to contain line item appropriation requests and authorizes the board to amend the budget.

SB 416, which is ostensibly a bill to prohibit fee splitting between a pharmacist and any person entitled to prescribe or dispense drugs, but the Governmental Affairs Council recommended that it be examined by legal counsel and the Executive Committee then take appropriate action.

ISMS will take no position on HB 997, which requires all physicians employed by the Department of Mental Health or practicing under its supervision to be trained in psycho pharmaceutics. SB 1059, the Illinois Hospital Association's rate review proposal, will not be opposed as amended. However, if the ISMS amendment—which exempts both physicians in private practice and those employed by hospitals—is removed, ISMS will oppose.

Obituaries

***Allison, Robert,** Vermillion, died May 20 at the age of 49. Dr. Allison graduated from University of Illinois 1950.

Balius, Edward, California, died May 28 at the age of 40. Dr. Balius graduated from the Stritch School of Medicine in 1960.

***Barrett, Howard,** Minonk, died April 17 at the age of 58. He graduated from the University of Illinois in 1941.

Dr. Barrett was chairman of Woodford County Unit of American Cancer Society.

****Barth, Walter,** Chicago, died May 19 at the age of 80. Dr. Barth graduated from Stritch Medical School in 1918. Dr. Barth had practiced medicine for more than 50 years.

Bieneman, Joseph, Michigan, has passed away at the age of 88. Dr. Bieneman was a member of the American and Illinois Osteopathic Associations.

Chung, Joseph, Chicago, died May 15 at the age of 59. Dr. Chung graduated from Northwestern University in 1944. Dr. Chung is credited with introducing and teaching the Pap test technique for detecting uterine cancer to the medical staff of Northwestern Memorial hospital.

Clark, Harriet, Oak Park, passed away May 15. Dr. Clark was a past member of Oak Park and West Suburban Hospital Staff.

Daly, Phil, Champaign, died May 12 at the age of 79. Dr. Daly graduated from Northwestern University in 1919. He served as president of the medical staff at Burnham Hospital in 1958 and president of the Champaign County Medical Society in 1960.

***Dushkin, Milton,** Chicago, died May 9 at the age of 64. Dr. Dushkin graduated from University of Illinois in 1934.

***Dvonch, William,** Oak Park, died May 3 at the age of 62. He graduated from Stritch School of Medicine in 1941.

****Elvidge, Ross,** Normal, died May 16 at the age of 84. Dr. Elvidge graduated from University of Illinois in 1915.

***Ginsberg, Robert,** Chicago, died June 5 at the age of 58. Dr. Ginsberg graduated from the University of Illinois in 1941.

Kelly, Maybra, Streator, died May 19 at the age of 75. Dr. Kelly received his degree from Washington University.

****Krost, Gerard,** Wisconsin, died June 6 at the age of 87. Dr. Krost graduated from Rush Medical College in 1914. Dr. Krost had practiced medicine for more than 50 years.

****Leech, Vernon,** Chicago, died May 16 at the age of 84. Dr. Leech graduated from University of Manitoba, Canada in 1917. He had practiced medicine for more than 50 years.

****Litvin, Nina,** Highland Park, died June 4 at the age of 86. Dr. Litvin graduated from Hankov, Union of Soviet Socialist Republics in 1914.

***Minnema, Clarence,** Winnetka, died June 10 at the age of 73. Dr. Minnema graduated from Rush Medical College in 1932.

***Olinger, David,** Elmhurst, died May 3 at the age of 61. Dr. Olinger was former chief of staff of Memorial Hospital and co-founder of the Elmhurst YMCA.

****Parker, William,** Mt. Vernon, died May 4 at the age of 88. Dr. Parker graduated from Barnes Medical College in 1910. Dr. Parker had practiced medicine for over 50 years.

***Sherman, Maurice,** Cicero, died Apr[illegible]9 at the age of 51. Dr. Sherman graduated from Chica[illegible] Medical School in 1951.

***Stotlar, James,** Pinckneyville, died May 14 at the age of 48. He graduated from University of Illinois in 1951.

***Strohmeier, Otto,** Evanston, died May 7 at the age of 77. Dr. Strohmeier graduated Rush Medical School in 1937.

Sours, Morgan, Bloomington, died May 15 at the age of 71. Dr. Sours graduated from Philadelphia College of Osteopathy in 1930.

**Indicates ISMS member*
***Indicates ISMS member and member of the Fifty Year Club*

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Illinois Medical Journal
Vol. 148, No. 1, July, 1975

The Umbrella of Love

By William Bauer, M.D./Chicago

As the child develops physiologically, he is also following a definite pattern of emotional development. Almost immediately after the feeling of omnipotence is invalidated—probably about the age of six months, he begins to cathect objects outside himself.[1] *At first, this bond—the primary emotional bond, if you will—is probably directed toward mother, or mother surrogate; but, by the time the child has passed the oral stage of development and perhaps long before that, the integrity of the marriage (or security of the environment) is probably cathected (invested with emotional energy) rather than any one particular parent* per se.

In a marriage with integrity, both parents are highly differentiated personalities operating within a wide base of mutual trust to provide security for their children. They are concerned with autonomy rather than controlling or being controlled. They are capable of demonstrating a great deal of initiative in maintaining an attitude of giving rather than getting. They are industrious and highly competent in adapting to each other, to the stresses of married life and to the needs of their children. This adaptation to each other and to life is seen as a constant challenge and as a constantly growing source of self-esteem. Each spouse has a strong sense of personal identity in this type of ideal relationship. These individuals have well-defined ego boundaries, their own unique differentiation, which provides them with the capacity to seek intimacy. Intimacy and autonomy, then, co-exist synergistically in the family relationship. The parents are close as a couple, but retain the responsibilities of individuality and freedom.[2]



WILLIAM BAUER, M.D., is an Attending Psychiatrist at Chicago Lakeshore Hospital and a consultant at Edgewater Hospital. He is also Chairman of the Adolescent Committee at Chicago Lakeshore Hospital.

Environmental Integrity

The freedom to communicate feelings, both appropriate and inappropriate, with the knowledge that these communications will be accepted for what they are without rejection or criticism is essential to the basic notion of mutual trust. An inappropriate feeling from the past communicated and accepted as such results in increasing closeness.

Only when a strong sense of identity (security) is present in both spouses can communications become truly creative. A crucial factor is the capacity for contributing and accepting new ideas, progressively reinforcing mutual respect. If this type of relating is mutual, then we have a didactic synergism of gratifying stimulation which serves as a model for the children. Developing and maintaining an identity becomes a dynamic process continuing throughout the years of the marriage. This process is furthered by meaningful interaction within the marriage, producing mutual creativity. Accomplishing creativ-

ity as a couple and as a family is synonymous with mature love.[2] The concept of allowing significant others to "be" (developing to the fullest potential of their unique individuality) is a concomittant qualification when defining love.

Mutual generativity and creativity become the vehicles for movement toward individual and marital integrity, and it is this environmental integrity (security) that the child finds so necessary for emotional development and learning.

Development

Within the framework of the type of cathexis which has been described, the personality is free to develop certain traits which contribute to a healthy adaptation. The reference here is to the work on imprinting done by Conrad Lorenz described in his book entitled "King Solomon's Ring."[3] In this book certain geese who were deprived of their mothers during critical early developmental stages are described. These geese were not frightened by the shadow of an artificial hawk. Obviously, this instinctive capacity to become alarmed under these circumstances was vital to their adaptive processes. When geese were exposed to their mother during the critical developmental period, they were alarmed by the artificial shadow.

By extrapolating this type of information and applying it to the child, we see that during the first year of life the child learns to trust or not to trust. If he learns to trust during this critical time, he is filled with a pervasive hopefulness for the future.[4] Erickson also tells us that during the anal period (from two to four years), if the child is exposed to a parental marriage (environment) with integrity, he will be able to develop traits of will power and self-control. During the third stage of development, at the age of five or six, if love and security are present, the child will proceed to acquire the trait of initiative, and he will have a sense of purpose in life. During latency, assuming that the same sense of security prevails, the child will develop feelings of competence and industriousness. Finally, by the time he has reached puberty, he will have a sense of identity, and he will be able to experience loyalty; these traits in turn will allow him to seek intimacy with a person of the opposite sex. He will then be able to experience normal generativity, creativity and fulfillment as an individual just as his parents before him.

Parental Insecurity

When the bond between the parents is ruptured or weakened they (the parents) begin squabbling over the available (ego) strengths. Frustrations and anger quickly follow, and the child is often drawn into the process as a surrogate spouse. A central problem in unsuccessful marriages often arises from the impairment of a sense of identity. When the tasks of adolescence are incomplete, an individual's role is shaky. The confusion of self-concept leads to bewilderment in relationships. A lack of identity and role confusion causes a couple to interact with bewilderment and anxiety. Bewilderment and anxiety corrode the positive bonds of a relationship and provide fertile soil for the growth of conflicts. The fear of intimacy and inability to meet the challenge of mutual creativity causes painful attacks, rejections, and ultimately regression to unresolved childhood patterns of behavior. The complexities of adjusting to the marriage with these patterns of behavior imposes an ever-greater burden on the relationship.[2]

"A self-perpetuating regressive chain of events leads eventually to a stalemate of covert or overt combat. The regressive traits tend to establish a new identity for the individuals involved. Frightened and angry, they continue to regress, and their relative maturity dissolves. The strength of the individual gradually consolidates in the service of defensiveness. The pathology continues to grow like a cancer. With a physical malignancy, tissues are destroyed. With an emotional malignancy of this type the life of the marriage is eventually snuffed out, and the residue is a symbiosis of despair."[2] There is ultimately a lack of integrity—both individual and marital.

The child, attempting to cathect (become emotionally involved in) this type of relationship, is perfused with insecurity. He is also unable to trust or be trusted, unable to obtain a sense of autonomy, lacks initiative and industriousness. When he reaches the age of adolescence, he experiences role confusion which, in turn, inhibits his interpersonal involvements, and prevents him from seeking the intimacy and fulfillment of a normal marriage.[4] He often rebels by acting out his frustration and rage.

Individual Responsibility

In attempting to establish a meaningful bond with our marital partners, it becomes essential that we assume personal responsibility for mak-

ing an effort to become an expert on the subject of ourselves and on the subject of relationships with significant others.[2]

Acceptance and understanding of another human being is catalytic to the emotional growth of an individual. Contact with another person, when made through appropriate verbalization of feelings, is a vital integrative force in the emotional development of the individual and in the relationship. The goal is to experience and communicate depth of feeling, appropriate as well as inappropriate (from childhood), with at least one significant other. Without this type of relationship, we have only emptiness (depression).[2]

Case Histories

Case I: A nineteen-year-old college student complained that she had nothing to live for and said that she intended to kill herself. She was hospitalized and during the course of several weeks of therapy, the following information was obtained: This child was the oldest daughter of a salesman. The salesman and his wife were seldom able to discuss their difficulties with one another and had gradually grown further apart emotionally through the years. The father had turned to his oldest daughter for emotional support and spent long periods of time discussing matters with her. When she was hospitalized, the father continued seeing her. He took her out to lunch, and took her for long rides in the evenings. The mother was not around during these times. As this relationship became more intense, the patient became more anxious. After returning from one afternoon pass with her father, she was found on the floor with a towel wrapped around her neck. She was cyanotic but recovered when the towel was removed. Her parents were immediately summoned. They arrived together shortly thereafter.

Following the suicidal attempt described above, the patient began to improve dramatically. Through the weeks after that, she revealed that she was markedly relieved to see that both mother and father had come to see about her. Seeing them together apparently had a therapeutic effect on this child. She was secure enough then to go ahead and work on her problems in therapy and gain enough insight to be discharged from the hospital three weeks later.

Case II: An engineer and his wife had two daughters. The couple related well on an intellectual level, but through the years they had grown distant emotionally. The mother turned to the oldest daughter for support while the father became very close to the younger daughter. The older daughter became promiscuous at the age of 17 and came in for treatment when she became illegitimately pregnant. About the same time, when the younger daughter reached 15, she came to the attention of the authorities because of her antisocial acting out in the community—"pot" parties, burglary, running away, etc. She was referred for treatment. Shortly after the younger daughter entered therapy, the mother and father came in asking for help for their own problems.

As time passed, it became evident that the older daughter had been frightened by the homesexual connotations of her relationship with her mother and had been struggling desperately to demonstrate her femininity by being promiscuous. The younger daughter seems to have been frightened by her father's intense interest in her and was unconsciously seeking a way out.

As the parents became closer, and all members of this family began to become aware of what was happening, the tension lessened, the security of the family was enhanced, and the acting out of the two daughters subsided.

Summary

The hypothesis is set forth that it is the integrity of the parental relationship (security of the emotional environment) which provides the matrix for the proper emotional and intellectual maturation of children. When the relationship is compromised, the valence of the triangle is skewed and the child is thrown into distorted relationships with his parents. This brings into play the use of defenses which are not ordinarily necessary such as denial and distortion. These defenses and the preceding repression may produce certain emotional illnesses of varying degrees. ◄

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Bacterial Endocarditis Following Open Heart Surgery

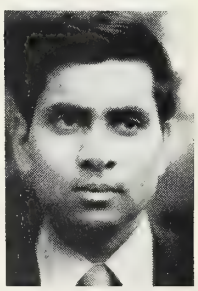
By Brojendra Agarwala, M.D., Thomas Baffes, M.D. and Aaron Grossman, M.D./Chicago

A case of acute bacterial endocarditis caused by an unusual organism, Bacillus Subtilis, following open heart surgery is being reported. This patient was treated successfully with high doses of intravenous Ampicillin for four weeks. To our knowledge no such organism causing bacterial endocarditis has been reported. The indication of surgical intervention when patient does not respond to vigorous antibiotic therapy has been reviewed.

A case of acute bacterial endocarditis immediately following open heart surgery caused by Bacillus Subtilis, an unusual organism, and successfully treated medically is being presented. To our knowledge no such organism causing acute bacterial endocarditis following open heart surgery has been reported. Indications for surgical management of patients with acute bacterial endocarditis following open heart surgery will be discussed.

Acute bacterial endocarditis is one of the most serious complications of cardiac surgery especially after insertion of foreign material. The susceptibility of the endocardial tissues to sepsis is increased by the insertion of foreign material.[1] The incidence of post-operative infection is reduced to less than one per cent by the use of non-wettable suture material, short duration of operation and prophylactive antibiotics.[2,3] However, after insertion of foreign material infection is still a problem both early and late following open heart surgery. The treatment is extremely difficult and mortality is very high.

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Our purpose is to present a case of acute bacterial endocarditis due to an unusual organism—Bacillus Subtilis. This occurred almost immediately after insertion of foreign material during open heart surgery. Our patient was treated successfully with antibiotics.

Case History

A four year old Black female was admitted for total repair of an unusual type of cyanotic congenital heart disease. She was a product of a normal, full-term pregnancy and delivery. Birth weight, 9 lbs. A heart murmur was first noted at two weeks of age and she developed congestive heart failure in early life which responded well to digitalis and diuretics. She was maintained on digitalis until a year ago. A cardiac catheterization was performed in August 1970, and the diagnosis of an aberrant muscle bundle within the right ventricle with ventricular septal defect was made. Recently, cyanosis on exertion was noted by her mother. A second cardiac catheterization in February 1973 prior to surgery confirmed the prior diagnosis.

Physical examination revealed a thin, intelligent Black female in no acute distress. Respiratory rate: 24/min.; heart rate: 100/min.; B.P.: 100/70 mm Hg; height: 93 cm and weight, 36 lbs. Body surface area was $0.69M^2$. No signs of overt infection were noted. The lungs were clear. Abdomen was soft and no organomegally noted. There was no edema or clubbing of extremities. Pinkish nail beds were noted.

The PMI was in the 5th left intercostal space in the mid-clavicular line. A faint parasternal heave and a systolic thrill along the left sternal border was noted. S_1 was normal; S_2 was widely split with diminished pulmonic component; S_3 was at the apex. A grade 4-5/6 ejection systolic murmur was heard best at left base with wide radiation along left sternal border. Diastole was clear. There was normal sinus rhythm. Electro-

cardiogram showed sinus tachycardia, normal QRS axis, evidences of right atrial hypertrophy and biventricular hypertrophy. Chest X-ray demonstrated a cardiothoracic ratio of 58 per cent. Evidence of biventricular enlargement was present. Pulmonary artery and vascularities were within normal limits.

Procedure

Cardiac catheterization demonstrated right ventricular pressure at systemic level. A peak systolic pressure gradient of 75 mm Hg between the high and low right ventricle. The ascending aorta was entered from low right ventricle. There was also bidirectional shunt at the interventricular level. Right ventricular angiogram demonstrated the aberrant muscle bundle dividing the right ventricle into two chambers (Fig. 1). The patient underwent open heart surgery in March 1973. The aberrant muscle bundle was removed. The ventricular septal defect was closed with a teflon patch and the right ventricular outflow tract was patched with a piece of pericardium.

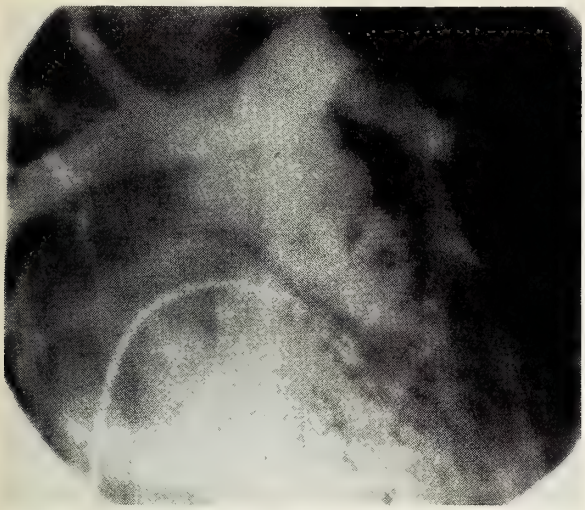


Figure 1. Right ventricular angiogram showing the oblique aberrant muscle dividing the right ventricle into two chambers.

Her post-operative period was complicated by persistent fever (Fig. 2). She was on Ampicillin and Prostaphlin from the day before surgery prophylactically. On the eighth post-operative day both antibiotics were discontinued and multiple blood cultures were obtained in two consecutive days. Nose, throat and urine cultures were also obtained. The chest wound remained clear and chest X-rays did not show any infiltration. Three blood cultures were positive for Bacillus Subtilis. Urine, nose and throat culture did not show any growth. The patient was started on

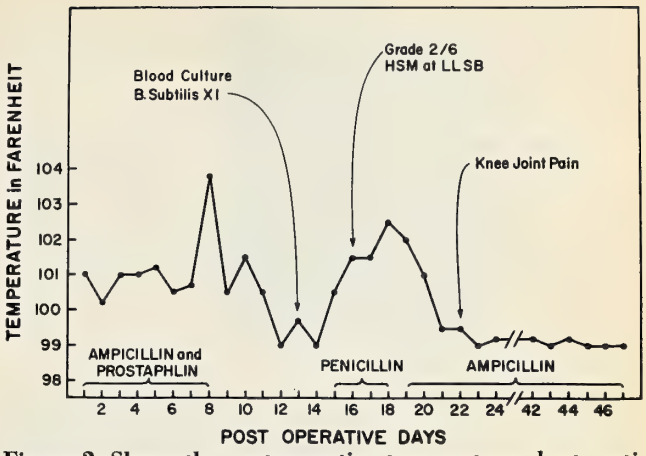


Figure 2. Shows the post-operative temperature chart, antibiotic therapy and major incidents.

intravenous penicillin 8 million units a day without any signs of improvement. Treatment was changed to intravenous Ampicillin 3 Gm/day and on the fourth day of Ampicillin therapy the temperature fell and patient appeared improved.

During therapy she complained of some vague pain in a knee joint without any other clinical manifestations. Very transient hepatosplenomegally was also noted. On the sixteenth post-operative day a grade 2/6 holosystolic murmur was heard along the left lower sternal border. She was digitalized from the first post-operative day and never showed any signs of congestive heart failure. Urinalysis did not show any hematuria. She received four weeks of intravenous Ampicillin therapy and was discharged on the 47th postoperative day. On follow-up she is doing well. No fever or any other manifestation of subacute bacterial endocarditis was noted.

Discussion

Bacillus subtilis is a gram positive spore-bearing, motile, straight rod which grows in long chains. This organism is found in brackish water, air and vegetable matter. Bacillus subtilis is frequently isolated from chronically infected wounds or sinuses. There are some reports of Bacillus subtilis meningitis and septicemia.[4]

Shafer et al.[6] reported 13 cases of subacute bacterial endocarditis following open heart surgery and their incidence of subacute bacterial endocarditis was 0.6 per cent. Four out of thirteen cases had congenital heart disease. The most common organism was found to be staphylococcus. In their series overall mortality was 77 per cent and 100 per cent in those with congenital heart disease.

Surgical intervention in some cases of subacute bacterial endocarditis following open heart sur-

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medical legal review

The Physician as Defendant in Malpractice Cases*

By Donal D. O'Sullivan, M.D., J.D., and Herman Wing, M.D., LL.B./Chicago

The physician defendant in a malpractice or professional liability case finds himself peculiarly vulnerable. His name is obvious in the hospital chart, whether he was the primary physician or not, and whether he was substantially responsible for the totality of the care received by the patient or not. His identity is available, and his reputation in professional activities can be marred or damaged by merely being named as a defendant, whether subsequently amended out of the complaint, or not.

Being named in the suit causes a whole sequence of legal processes which tend to remove the physician from those activities necessary and vital to his patient's health and welfare. The physician can understand the necessity for the legal case to be properly prepared; he can understand the involvement of the primary defendant in the preparation of his defence. However, he often finds it difficult to justify the casual and cavalier way in which his work-schedule, and his patients' convenience, if not their health, is disrupted for little or no apparent benefit to the plaintiff or to the primary defendant.

Whether primary defendant or merely a physician with a tangential identification in the case, the physician is faced with a number of conundrums in the current pattern of professional liability litigation. For example:

If one considers the incidence of successful suits as a ratio to risk, that is, the total number of patient/physician contacts in the area or time period under study, the occurrence of a liable negligent act is far less than 0.001%—a much better record than is found in many human endeavors.

There appears to be a distortion in the cause-effect relationship between the act, or omission to act, on which the claim of liability is based, and the dollar value assigned to that act by the court. This is particularly illustrated when it is recalled that the patient who was the beneficiary of the medical act under examination was not "risk-free," but, on the contrary, was in a medically precarious situation at the time.

In effect, this situation implies the physician a guarantor of the results of care; for when the results of the condition and the treatment are not perfection, or at least within the patient's expectation, the allegation of malpractice may follow. The physician or the hospital then may be placed in the position of paying the social cost of the patient's loss of wages, loss of consortium, loss by disease, or injury—all losses which were inherent in the presence of the disease in the first place. To cite one example: in any anesthesia case, the condition requiring the administration of an anesthetic is present in the patient before another physician performs his service. The patient's medical condition may be deadly, or debilitating, and may require some intervention in order to change the course of events. Thus, a patient is in jeopardy before the anesthetic is given. The administration of the anesthetic adds to this jeopardy. It seems a distortion to equate the entire loss that may be suffered by the patient to the effects of the anesthetic and thus hold the anesthesiologist liable for all the patient's losses.

The theory of negligence or fault as the basis of liability is not consistently applied. The misuse of the *Res Ipsa Loquitur* doctrine to get a case to the jury, when expert testimony is clearly necessary to demonstrate negligence, is distressing. Application of doctrines of strict liability in cases related to drug use or blood transfusion is equally disturbing as a judicial interference with sound medical judgment, to the detriment of the patient. The use of drug package inserts to define the limits of responsible medical use is retrogressive in that it impedes medical progress.

Rigorous interpretation of documents such as the By-laws of the Hospital to define proper procedures—without judicial recognition of scientific meaning, the Administrative Agency approach, or the practical genesis of such documents, (the "legislative history," if you will)—is not only perverse, but is recognized by the experienced, conscientious physician as an unscientific and illogical distortion of reality, demonstrably not in the best interests of society as a whole or of the individual patient.

On a more individual or tactical level, the physician is disturbed by the wholesale or shotgun approach of the plantiff's attorney who names everyone remotely connected with the case in the complaint, when even superficial investigation would demonstrate unequivocally that if liability actually exists, it lies with only one or two of the named defendants. Since the mere naming of a physician as a defendant, with or without merit, seriously jeopar-

*Remarks prepared for the conference on "Malpractice and the Doctor Defendant," presented at the Illinois State Medical Society's annual meeting and clinical conference, April 3, 1975.

dizes his insurability, this particular practice is demonstrably counterproductive in the overall societal situation created by professional liability. Even in states which adhere to the "fact-pleading" mode of drawing a complaint, such as Illinois, the term "facts" is very losely interpreted and little truly factual material is necessary to allow allegations of negligence to be made against very peripheral actors.

While the writers do not deny the existence of true malpractice, and while the writers do not presently propose a completely non-judicial system that would adequately protect the rights of the patient and physician alike, we do believe that relatively minor modification of the procedure by which society now handles claims of professional liability can be of benefit to both patient and physician. We therefore suggest:

1. A Medical Liability Review Panel to eliminate the rapidly terminable claims without substance or involving minimal damages. This review panel should be staffed by knowledgeable physicians and attorneys, and with a consumer element representation. Rules of procedure should be developed so that concepts of due process, and immunity for panel members are assured. The findings of the panel should be obtained with sufficient formality to allow them to be the basis of an arbitrated settlement; or in the alternative, to be admissible as evidence in any trial *de-novo* that may follow dealing with the same actionable incident.

2. There should be protection of the professional reputation of the defendant physician and hospital in that publicity concerning the claim and the alleged injury should be postponed until some substantiation of the facts is documented. Under the present procedures, the mere filing of the claim, frequently before any significant investigation of the events has been made, subjects the putative defendants to widespread adverse publicity. The effects of such publicity cannot be overcome, even when subsequent findings completely exonerate the defendant doctor or hospital. In a very real sense, the hospital and the physician are necessary community support assets which can function for the good of the community only during the retention of a good name and the confidence of the community. It is contrary to the public good to have this confidence shaken without adequate and sufficient cause, demonstrated before a competent tribunal.

3. Reestablishment of the Statute of Limitations as a practical and functioning bar to stale, or no longer defensible, claims due to failing memories or loss of records. It seems reasonable to expect that any untoward result of medical care will be manifest within a relatively brief period—one or two years at most; any such bad result that is correctly the basis of a claim can be objectively and accurately assessed by a panel, or by a court, when it is timely evaluated. With the delays now so frequent, it is not unusual for a physician to find himself required to defend his therapy of a disease condition after so many years have elapsed that the scientific understanding of the disease condition has substantially changed and the therapeutic approach has significantly matured. This subjects the defendant to functional *ex-post-facto* criteria of conduct, to the detriment of real justice. This particular detrimental aspect of present procedure is evident in the pediatric cases that conceivably may not come to trial for twenty or more years after the medical event, allegedly the source of liability, has occurred. Such claims are difficult to defend under the best of conditions.

4. The cost of the litigation should be assessed to the losing party, whether plaintiff or defendant, rather than being assessed to the losing party only when it is the defendant. We believe that such a procedure would go far to discourage the frivolous or unmeritorious suit. A bonding mechanism could be employed to ensure responsibility on the part of the plaintiff and his attorney in the bringing of the suit and claim.

5. There should be a redistribution of the monies realized by the collection of insurance premiums paid as protection against liability for professional acts. It is now alleged by various sources that the successful claimant realizes only a small portion of the premium dollar allocated to his claim. Depending on the source and the manner of calculation, this portion is variously estimated as being between twenty and thirty-eight percent. In either case, the majority of the premium dollar is not finding its way to the successful, and truly damaged, claimant. This maldistribution of the monies available should be repaired.

6. Since we recognize that there are episodes of physicians acting beyond their competence, we believe that there should be a viable mechanism to discover and control the activities of those physicians who, because of age or other reasons, have demonstrably failed to maintain a professionally acceptable level of medical competence. At the present time, in Illinois, such a mechanism is only in the initial stage. The Illinois State Medical Society proposed a new Medical Disciplinary Act to the General Assembly. This can go far to correct a present deficiency in the protection of the patient/consumer offered by the current Medical Practice Act.

7. The system of specialization that has been developed in medicine to define areas of competence and medical privilege within professional circles has been demonstrably sound in its approach and in the ultimate protection of the patient. We note that this specialization and its standards are used by the courts to define the criteria of care rendered by the individual defendant physician. We would welcome the application of the same criteria of expertise to the qualification of expert witnesses before the court. We find it ludicrous to hear the testimony of physician witnesses who claim knowledge of medical events far beyond their competence, their experience, and their expertise. We would welcome the same discrimination in the selection of expert witnesses as is demonstrated in the selection of "community standards" by which the defendant is judged.

8. Since the Emergency Room has become the focus of much medico-legal activity, and is the source of many of the liability claims that are brought, we believe that it is important for the community to re-evaluate the position of the emergency room, and to objectively assess its purpose and the scope of its activities. While the emergency room is considered by many patients as a convenient twenty-four hour out-patient clinic, the physician tends to view it rather as the place for true emergencies to receive the attention and the support of extremely sophisticated medical instruments and physicians. As such, the emergency nature of the work there performed should be recognized by the community at least to the extent of providing emergency room personnel and attending physicians with the same protection against liability extended to other emergency community services, such as the police and fire departments. This should take the form of statutory declaration of non-liability in the absence of wilful and wanton negligence, in the emergency care of the ill.

9. Some means must be found to protect the practicing physician from the looming threat of bankruptcy contingent on one inadvertant mistake in a lifetime of devoted professional service to the community. Some means

(Continued on page 66)

Considerations in Prolonging Life— A Dying and Recovery Score

Part II

By Vincent J. Collins, M.D./Chicago

Part I of this article was published in the Illinois Medical Journal, June, 1975.

Diagnosis of Death

Death is a diagnosis. Such a diagnosis must be made by a qualified physician. The imminence of death or a conclusive set of circumstances leaving no alternative or hope is a medical decision.[8] The law cannot make a determination of death but it can designate the person who is competent to do so. The first skillful statutory definition of death in the history of Common Law has been drafted by the State of Kansas. It leaves the determination of death in the hands of the attending physician at the scene of death.[9]

The recognition of death is one of diagnosis based on logical thinking. The diagnosis of conclusive death and the decision that there is no likelihood of recovery must be established on customary medical and scientific observations and tests. This may be done in consultation or by a "Committee on Reanimation" of two or three physicians in a hospital with expertise in these matters. Such a group might well consist of an anesthesiologist, neurologist, cardiologist and cardiac surgeon.

As with any diagnosis, the patient must be examined by a physician. Death is dependent upon the observations made, the signs and symptoms or lack thereof. Five physiologic components must be assessed and tested; the mental, sensory, motor, reflex and autonomic activity. These are the criteria and determinants. No single clinical factor, indeed, no single observations such as stoppage of respiration or stoppage of cardiac action or cessation of nervous system activity can today be considered sufficient or adequate by itself to establish a diagnosis of death. No single factor can stand alone in the differential diagnosis of any disease or be the final determinant. The decision to abandon efforts to revive the patient must rest on many signs and observations. The diagnosis or decision is initially presumptive, but with current technics the decision can be made conclusive.

Establishing Clinical Death

The task is to establish the fact of death. This fact will then identify the time when clinical death is certain and resuscitation procedures have no possibility of reanimating the organ systems to an integrated whole with a full human potential. At this point biological death is imminent, even though the individual life processes of many organs may be present. The diagnosis of clinical death should be stated by the physician on the chart. Thereafter extraordinary measures of resuscitation may be withdrawn or abandoned.

One should not consider any other factor but the medical status in arriving at a decision. When the virtues of continuing life-sustaining measures are questioned the physician should inform the family about his diagnosis and its pros and cons.

The Dying Score

To assist the physician in this serious matter of determining the end point of life (vital and biologic) the concept of a score to determine death is proposed. To a degree this score parallels the Apgar Score, or living score for newborn babies.[10] It is asserted as a basic premise that no single sign or function be used to assess the capacity to live nor establish the state of death. No single sign is adequate to determine total capability for human existence or the lack thereof. Patients should be evaluated according to several signs of life.

Five physiologic functions have been selected for appraisal of their presence, their potential, or their absence. An arbitrary scoring system of 0, 1 and 2 is used. The physiologic functions selected are all of critical and vital importance. However, they are not all of equal importance but are interdependent for spontaneous life. (Table III) Nor are these functions listed in their order of importance, but to some degree there is an increasing order of dependence. The irrevocable absence of one of these functions or the inability to perform spontaneously precludes the ability of the others to perform efficiently.

In applying the score, an initial value is obtained as soon as the artificial resuscitation procedures have been instituted and the requirements of emergency care satisfied. It is then recommended that serial determinations of a score be made every 15 minutes over a period

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TABLE III
Recovery and Dying Score in Comatose Patient

Sign	2 Normal	1 Abnormal	0 Absent
Cerebral Function	Normal	Depressed	Absent
EEG	Alpha	Spikes	Isoelectric
Stimulus—Light Temp		Evoked Response	No Evoked Response
Reflex Action	Present	Diminished	Absent
Eyes	Constricted Pupils	Pupillary Response	Dilated
Laryngeal	Pharyngeal Reflex	Laryngeal-Carinal	
Tendon Reflexes			
Nerve Stimulus		An Evoked Response	No Evoked Response
Respiration	Normal	Abnormal	Absent
	Spontaneous	Assisted	Controlled
	Adequate		
Doxapram Test	Present	Evoked Response	No Response
Circulation	Normal	Depressed	Absent
	Pulse	No Pulse	
	Pressure	No Pressure	
		Artificial Support	
Vasopressor Test	Not Needed	Evoked Response	No Evoked Response
Cardiac Action	Normal	Ineffective	Absent
	Heart Sounds	Assisted	
ECG	Normal	Abnormal	Isoelectric
Pacemaker	Not needed	Evoked Response	No Evoked Response

1. Initial evaluation as soon as artificial resuscitation procedures have been instituted.
2. Serial determinations at least every 15 minutes.
3. A score of 5 or more indicates potential life. A score of under 5 indicates *impending* or presumptive death.
4. A score of 0 is *conclusive* death.
5. An increasing score over a period of 1 hour represents effective therapy and patient recovery.
6. A decreasing score over a period of 1 hour represents failing therapy and patient deterioration.

of 1 to 6 hours. Such a working plan will show a trend and be of predictive value. A score of 5 or more points represents potential life. A score of under 5 points represents impending or presumptive death. A score of 0 is conclusive death. It is further noted that an increasing score over a period of two hours indicates effective therapy and patient recovery; while a decreasing score over a period of two hours indicates failing therapy and patient deterioration. To the clinical observations, there may be added laboratory, pharmacologic and monitoring tests of function and responsiveness.

Cerebral Function

In the absence of consciousness, one assumes a depression or the loss of cortical function. Initially this may be reversible. During this reversible period sensory stimulation should be tried to evoke responses. At first, these are somatic in nature but later only the visceral or neurovegetative type of responses will be evoked and one may define a state of irreversible coma.

Muscular movements may be observed and if noted to be purposeful, coordinated, and spontaneous, a score of 2 would be assigned. When such movements are altered, incoordinate, and without purpose, and are only observed when induced by strong stimulation, a score of 1 would be assigned. When such movements are absent and cannot be evoked by strong stimulation a score of 0 is assigned.

The electroencephalogram may show progressive deterioration.[7,10] When spike bursts alternate with periods of suppression, depression of cortical function is evident. This pattern would represent a score of 1. When complete silence and an isoelectric potential is observed and there is a loss of evoked potentials, a score of 0 is assigned.

The method of electroencephalographic study primarily reveals changes in cortical function and may be highly suggestive of cortical dysfunction. This method does not necessarily reflect the capacity of the organism to be revived, nor does it reflect the existence of cellular life throughout the cerebral axis. The actual patterns of electrical activity should be assessed when amplification is maximal.[7] Rather than a flat pattern one should speak of an isoelectric pat-

tern. These cortical patterns may be easily silenced by many stresses: drugs, shock, trauma. Yet the body can be brought back to full life. An isoelectric pattern without evoked responses over 2-6 hours is highly suggestive of cortical death and cerebral disorganization. But it is not conclusive and must be assessed concurrently with the other clinical signs and responses of other organs.

It is emphasized that the electroencephalogram reflects cortical function only! It does not indicate total brain (cerebral) function. Special reliance on this type of study can be misleading since it is not the single key to the determination of life or death.

Reflex Excitability

This function is evaluated by the observation of several responses. First, the size of the pupils is observed. Constricted pupils are evidence of good central nervous control at the diencephalic level and a score of 2 is warranted. Dilated pupils indicate a loss of such control. However, the testing of the dilated pupil by light stimulus and evoking some constriction indicates the capacity to recover and dictates a score of one. Many other sensitive reflexes may be stimulated in sequence. One can progress from the eyelid reflex to the pupillary light reflex to the pharyngeal, laryngeal, and carinal reflexes. Stimulating the larynx, trachea and carina usually evokes a modified cough or "buck". In deep coma no response occurs and a score of zero is indicated.

Respiration

The presence of spontaneous and adequate respiratory efforts dictate a score of 2. When breathing becomes abnormal and requires assistance, a score of 1 is assigned. If sponteaneous respiration is absent, but the administration of a respirogenic drug (i.e. doxapram) evokes a spontaneous respiratory effort, a score of 1 is also assigned. When respiration is absent, complete artificial control is required and the drug challenge to the respiratory center and to the pulmonary apparatus does not evoke a response, a score of 0 is indicated.

Circulation

The presence of the circulation can be determined by detection of peripheral pulse, estimation of a pressure and the observation of the capillary refill phenomenon in the skin or nail bed. A more sophisticated method of assessment of circulatory function is the observation of retinal vessels by ophthalmoscopy. The presence of a measurable blood pressure, of a palpable pulse and good capillary refill suggests a score of 2.

The absence of an estimable blood pressure and the absence of a peripheral pulse with no capillary refill, but the presence of a detectable large artery pulsation indicates a score of 1. The score can be further verified by evoking a pressure response with a peripheral-acting vasopressor or by observing movement of blood in the eye grounds.

When no pulsation is detected in large arteries and there is no evoked response to a vasopressor, a score of 0 is justified.

Cardiac Action

For a score of 2, a spontaneous palpable cardiac thrust over the chest wall should be present and a peripheral pulse detected. Auscultation should reveal a regular heart beat, with the ECG of normal configuration.

When the heart beat is not detected by palpation and weak, ineffective contractions exist as evidenced by normal heart sounds coupled with an incoordinate bizarre pattern in the ECG, a score of 1 is assigned. Cardiac resuscitation measures should be needed and cardiac assistance indicated. A pharmacologic stimulus to the heart, such as the injection of isoproterenol or epinephrine should evoke a response. In addition an intravenous cardiac pacemaker may need to be employed at this critical time.

The absence of any spontaneous cardiac activity and no ECG electrical activity demands artificial circulation by cardiac compression ("massage"). The failure to respond to a pharmacologic stimulus or for the electrical pacemaker to produce an effective cardiac contraction determines a zero cardiac score.

Secondary Considerations

Other factors than the medical and scientific operate in our complex, pluralistic society. Aspects such as the economic, social, family, emotional, legal as well as religious also are present. However the physician must remain aloof from these influences and pursue his art to the best of his ability. If the logic of the physician and the science of medicine operate clearly and unencumbered a proper decision will be reached in regard to the patient and the best interests of all will be served, whether they be economic, family, legal or religious. Whatever reasonable and rational course of ac-

Model Form
THE VIABILITY SCORE

Evaluation of recovery potential for differentiation between clinical and biologic death.
Patient:

FUNCTION	Present (value 2)	Abnormal (value 1)	Absent (value 0)
I. CEREBRAL			
Stimulus:			
(1) Light			
(2) Temperature			
(3) Pain			
EEG			
II. REFLEXIVE			
1. Ocular			
2. Laryngeal			
3. Tendinal			
4. Neuromuscular			
III. RESPIRATORY			
1. Doxapram			
IV. CIRCULATORY			
1. Vasopressor			
V. CARDIAC			
1. Auscultation			
2. ECG			
3. Pacemaker			

Check the various signs:
TOTAL SCORE —

_____ _____ M.D.
Witness

_____ _____ M.D.

_____ _____ M.D.
Date

To be made a part of patient's chart.

tion is best for the patient will inevitably coincide with the best interests of the family if the care is humane and personalized.

Whose Responsibility?

When the virtues of continuing life-sustaining measures and the relief of pain, or the determination of futility of the therapy and the establishment of the presence of death are under consideration—who else can weigh the pros and cons but the physician? The solution to the dilemmas or contradictions faced in prolonging life or delaying death or of recognizing one or the other is the responsibility of the medical profession. In reaching a decision one should not consider any other factor but the medical status of the patient and his welfare.

What About the Legal Responsibility?

Under no circumstances can the law determine death. Physicians must do this for society and then provide common law grounds for action. The law can designate who shall determine the state of death. Present law clearly recognizes that the pronouncement and certification of death is that of a physician. The responsibility of decision rests squarely on the shoulder of the physician. But the old definitions in law and even in medicine, emanating from long practice, are now inadequate. It is necessary for medicine to recognize determinants of death, to recognize a time for decision and a time to make decisions.

The law is only secondarily involved. After death is certified by the physician, the law operates to dispose of a decedent's estate. It is understood that the law also operates to prevent a physician from performing unscientific therapies or to challenge him for negligence. In the eyes of the law, the traditional signs of death are those consisting of a person whose "breathing has stopped" and who has "no pulse." But something more scientific and conclusive than this is needed.

Perhaps the most lucid exposition of the subject of "Prolonging Life" and the legal aspects of any medical decision regarding death is that of Law Professor George P. Fletcher of the

University of Washington. He states:

> "The responsibility for the patient's expectations lies with the medical profession as a whole.
>
> The medical profession (not the legal profession) confronts the challenge of developing human and sensitive customary standards for guiding decisions to prolong the lives of terminal patients.
>
> They should have a clear standard for deciding when to render aid or not to the dying patient."

What About the Religious Responsibility?

Major religious leaders have clearly indicated that it is the doctor's responsibility to conclusively establish that death does, in fact, exist. I should only quote from Pope Pius XII in this regard. In answer to the question "When does death occur?," proposed at the International Congress of Anesthesiologists in Rome, November 24, 1957, Pope Pius XII stated:

> "Human life continues for as long as its vital functions, distinguished from the simple life (biologic) of the organs, manifest themselves spontaneously without the help of artificial processes.
>
> The task of determining the exact instant of death is that of the physician."

Summary of Responsibility

In summary, it is evident that in the area of prolonging life and determining death it is not a theological or legal responsibility. It is clearly a medical responsibility. There are three primary determinants regarding the limits of medical responsibility. First is the physician-patient contract which involves a surrendering of certain features both physical and psychological of the natural rights of privacy of the individual to the doctor. Second is the ethical guidance and motivation of the physician's personal code of ethics. And, third, the science and art of the physician as exemplified in his wise application of knowledge and diagnostic ability.

It is the purpose of this paper to present the concept of "multiparameter scoring," to provide an end point defining irreversible clinical death at a time when biological organ death has not occurred. As the technology of prolonging life and the science of organ transplantation has progressed, the need for such an end-point has become increasingly apparent.

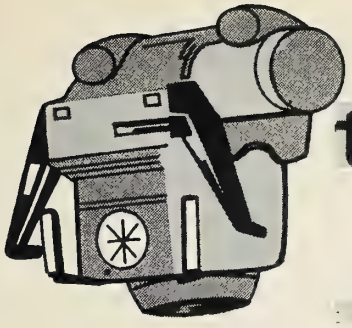
A "model" score sheet currently being utilized is presented. This will undoubtedly be modified as experience is gained in multiparameter scoring. At least three objectives may be realized by such a scoring system:

> (1) The physician can decide when efforts at resuscitation are no longer successful and should be abandoned. This will allow the patient to die peacefully and not in pieces.[3]
>
> (2) The score permits the anesthesiologists and the intense care physician to quantitate the stages of recovery from anesthesia or assess the recovery from coma.
>
> (3) A precise system, based on sound medical and scientific principles will protect any potential donor from even the possibility of precipitious removal of organs. Death can be pronounced without the shadow of doubt before artificial and extraordinary supports are terminated and any organ removed for purposes of transplantation.

Thus, the interests of patient, physician and public will all be served. ◄

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the view box

LEON LOVE, M.D./CHAIRMAN/DEPARTMENT OF RADIOLOGY
LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This patient was a 27-year-old female who complained of a gradually increasing mass over the past three months. Physical examination revealed a cystic non-tender large football sized mass in the left upper abdomen. (Figures 1, 2 and 3)



Figure 1

What's your diagnosis?

1. Renal Carcinoma
2. Giant Hydronephrosis
3. Multicystic disease of the kidney
4. Renal vein thrombosis

(Answer on page 81)



Figure 2



Figure 3

Pediatric Perplexities
Ruth A. Seeler, M.D,. Editor

NEONATAL POLYCYTHEMIA HYPERVISCOSITY SYNDROME

By Rajam S. Ramamurthy, M.D., Joyce E. Royal, M.D.,
Suma P. Pyati, M.D., and Ruth Andrea Seeler, M.D./Chicago

The neonatal hyperviscosity syndrome associated with polycythemia presents with tachypnea and cyanosis within the first few days of life. It is important to differentiate this entity from cardiac and respiratory diseases in order to institute immediate therapy, the failure of which may result in permanent central nervous system damage. Therapy, a simple phlebotomy, can and should be performed in any nursery by the pediatrician as soon as the diagnosis is established.

This report of two infants demonstrating the classical problems of hyperviscosity syndrome includes a discussion of the pathogenesis and recommended management.

Case I

A 3,714 gram male infant was transferred from another hospital to the neontal intensive care unit of Cook County Hospital at 6½ hours of age because of mild respiratory distress. The labor and delivery were normal, the infant was meconium stained and 3-4 weeks post-term. Physical examination revealed cyanosis, respiratory rate of 106-120 per minute, heart rate of 140-160 per minute and the liver extended 2 cm below the right costal margin. The chest roentgenogram revealed clear lung fields and minimal cardiomegaly. The transfer diagnosis of meconium aspiration was rejected.

The infant was hypoglycemic with a plasma glucose of 20mg%. Despite intravenous infusion of 10-15% dextrose, the glucose fluctuated between 30-50mg%. The capillary hematocrit was 75%. A complete blood count the following morning showed the hematocrit to be 84% with a hemoglobin of 26.2 gm/dl and RBC of 6.95mil/c.m.m. There were 1,980 normoblasts per 100 WBC, and the platelets were markedly diminished on peripheral smear. The infant's blood was 77.8% hemoglobin F and 33% hemoglobin A.

A 50cc phlebotomy with salt poor albumin replacement lowered the hematocrit to 66%. Over the next few days, the respiratory symptoms gradually diminished, plasma glucose was normal, normoblastemia cleared and platelets returned to normal. There were no neurological abnormalities at the time of discharge.

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Case II

A 4,621 gram male infant was transferred at 24 hours of age because of sweating, circumoral cyanosis and radiological evidence of cardiomegaly. Infant was born to an obese mother by normal vaginal delivery with an Apgar score of 8.

On admission to Cook County Hospital, the infant was noted to have drooping of the left corner of the mouth and mild hypertonia of extremities. The venous hematocrit was 80%. Phlebotomy was done removing 50cc of blood and replacing it with 50cc of salt poor albumin.

At 48 hours of age, the bilirubin was 12.6mg and he was started on phototherapy. Because of lethargy, a sepsis work up was done and antibiotics were started. At 96 hours of age, a generalized convulsion occurred and was controlled with diazepam. Seizures recurred despite appropriate dose of phenobarbital. Although the hematocrit was 64%, additional 30cc phlebotomy was done. Infant became oliguric. No RBC's were present in the urine. During the next few days, urine output improved, convulsions were controlled and baby started feeding by mouth. IVP, which was done to look for evidence of renal vein thrombosis, was normal. Neurological evaluation is suggestive of some brain damage; however, long-term follow up will be done to determine the extent. The EEG was within normal limits for age.

Discussion

The association of polycythemia (central venous hematocrit over 65%) and the symptom complex consisting of plethora, tachypnea, cyanosis, cardiomegaly, hypoglycemia, hyperbilirubinemia and central nervous system manifestations in the

neonate has been reported.[1] Decreased erythrocyte deformability is the major determinant of blood viscosity in the neonate. The other cause of hyperviscosity such as increased or abnormal plasma proteins is not a significant factor in the etiology of neonatal hyperviscosity.

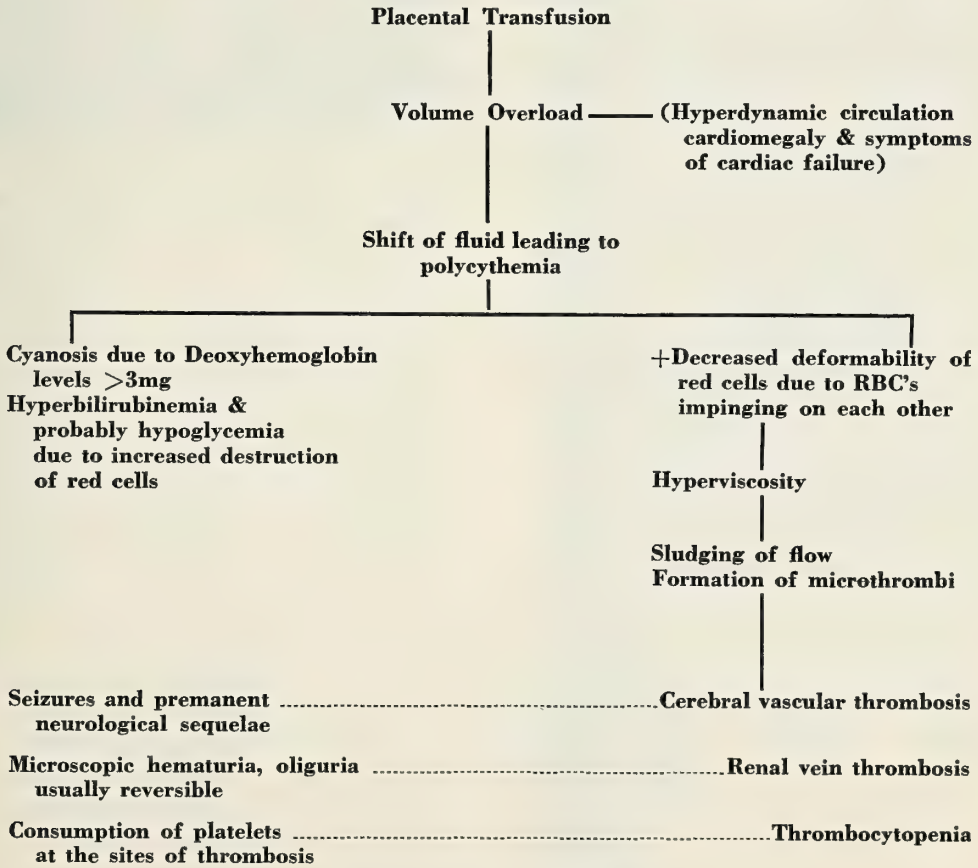
Among the recognized causes of neonatal polycythemia (Table 1), placental transfusion during delivery is probably underestimated because in many nurseries hematocrits are not routinely performed. The neonate's hematocrit is directly dependent upon obstetrical practice. Delayed clamping of the cord can permit a placental transfusion giving rise to as much as 50% increase in blood volume.[2] In our institution, the umbilical cord is clamped immediately after birth while the infant is held level with the mother's perineum. A hematocrit is done on all normal infants at 3-5 hours of age after stabilizing the body temperature. When the peripheral (heel stick) hematocrit is over 70%, a venous hematocrit is immediately obtained. Not infrequently the baby has a ruddy appearance with peripheral cyanosis. The color alone may be misleading as in the two infants described. In the last two years, since hematocrits are done routinely, we have encountered a 5% incidence of polycythemia.

Table 1. Causes of Neonatal Polycythemia

Placental transfusion at delivery (mainly due to gravity	**Delayed cord clamping** **Maternal-fetal transfusion** **Twin to twin transfusion**
Placental insufficiency (due to hypoxic stimulus increasing erythropoitin)	**Small for gestation infant** **Smaller of the twins** **Post maturity**
Miscellaneous causes	**Infants of a diabetic mother** **Down's Syndrome**

The pathogenesis of symptom complex in hyperviscosity syndrome is depicted schematically in Figure 1. Occasionally, hyperviscosity may occur at hematocrits within upper limits of normal in which case determination of actual blood viscosity may be necessary to make the diagnosis.[3]

Figure 1. The Pathogenesis of Hyperviscosity Syndrome



(Continued on page 53)

Cysticercosis Cerebri

By William C. Hanigan, M.D., Lenard Rutkowski, M.D.,
Byron M. Bloor, M.D. and Victor Canelas, M.D./Maywood

The infection of the central nervous system (CNS) by the adult pig tape worm, Taenia solium is uncommon in the United States, particularly the Midwest region. Moreover, the incubation period is such that long periods of time may elapse between initial infestation and clinical presentation.[1] *Consequently, a patient harboring the parasite who has not travelled out of the country for many years may present with a wide spectrum of complaints referable to the CNS. This case is reported because of the interesting mode of presentation, the clinico-pathologic findings and the uncommon incidence in this region.*

Case History

This 50-year-old United States citizen of Mexican extraction was referred to Hines VA with a diagnosis of pituitary tumor. On admission the patient was obtunded and unable to give an adequate history. The patient's family, living in Mexico, was contacted and reported the history.

The patient had lived in Chicago for approximately twenty-two years. He made his first trip to his previous home 4 months prior to this admission seeking medical attention for intractable headaches. While there the family noted spells of lethargy and progressive personality changes. A neurological examination performed at this time was reported as normal while skull radiographs (Fig. 1) demonstrated demineralization of the sellar region. After returning to Chicago his condition deteriorated over a period of several months and friends brought him to a local hospital from which he was referred to Hines VA.

The neurological examination revealed a poorly nourished male unable to respond to commands. The cranial nerves appeared intact. Both pupils were equal and responded to light. The funduscopic examination revealed papilledema of two diopters with no evidence of hemorrhage. The neck was supple but muscle tone was poor. Spontaneous movements did not demonstrate a focal paresis. The deep tendon reflexes were equally hypoactive with an equivocal Babinski reflex on the right. Initial laboratory examinations including CBC and differential, VDRL, urinalysis and SMA-12 were within normal limits. Skull radiographs were essentialy unchanged from those obtained in Mexico four months previously. The brain scan was interpreted as normal while an EEG demonstrated bilateral rhythmic delta waves greater in the frontal region. Stool for ova and parasites were negative, as well as soft tissue radiographs for calcifications.

Selective left carotid and vertebral angiography (Fig. 2a, 2b and 3) demonstrated dilitation of the entire ventricular system. The patient was placed on dexamethasone and a right ventriculoperitoneal shunt was performed. CSF analysis at

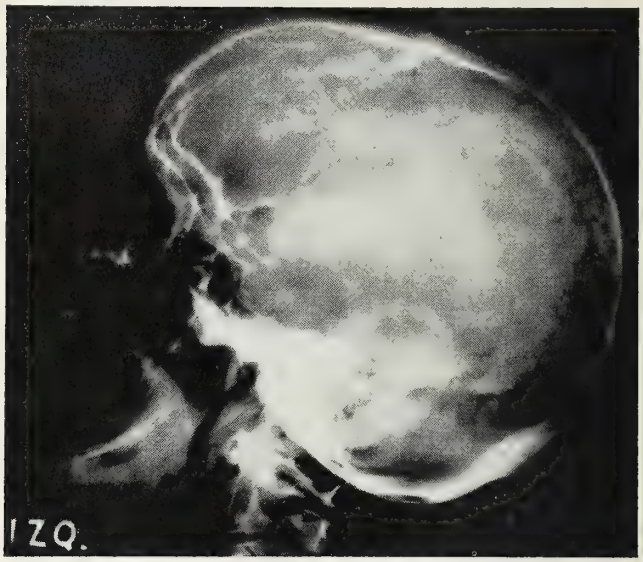


Figure 1. A lateral radiograph of the skull showing marked enlargement and demineralization of the sella turcica. There is erosion of the posterior clinoids. No intracranial calcifications are seen.

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Figure 2a. A lateral carotid angiogram in the arterial phase showing marked bowing of the anterior cerebral artery (arrows).

this time was unremarkable. Following surgery, over a ten day period, he began to ambulate and respond to simple questions. Subsequent pneumoencephalography confirmed the arteriographic findings. (Fig. 4)

A suboccipital craniectomy performed one week later revealed a marked degree of arachnoiditis involving the dorsal aspect of the upper medulla and base of the fourth ventricle. Several cysts were seen at the base of the fourth ventricle which were removed in toto. Further exploration of the posterior fossa failed to reveal any pathology.

The patient remained stable for two weeks following surgery. Gradually, over the next six weeks his condition began to deteriorate with development of a bilateral paralysis of the tenth through twelfth cranial nerves. In an effort to stop the clinical progression the V-P shunt was revised from a high pressure to low pressure value. However, this was of no value and subsequently the patient expired sixty-two days after the craniotomy.

An autopsy was performed which revealed marked basilar arachnoiditis of the brain stem with evidence of severe hydrocephalus. No cystic lesions were seen in the remaining areas of the brain. The tissue specimens obtained at surgery revealed thickening of the pia-arachnoid at the base of the brain with marked infiltration of mononuclear cells. The characteristic three layered wall of the cysticerci was demonstrated. (Figure 5)

Discussion

The disease entity of the cysticercosis cerebri is extremely uncommon in this region. The last reported case is that of Kassis et al., in 1967.[2] The mode of presentation, the skull films obtained in Mexico and the extent of arachnoiditis seen at surgery suggests that the inflammatory process in our patient developed over a long period of time. This is consistent with previous reports of incubation periods lasting many years.[1]

However, it is reasonable to postulate that an initial episode occurred while in Mexico five to six months prior to this hospital admission. Due to the difficulty of obtaining a full and adequate history, the question remains unanswered.

The parasite is endemic to Latin and South America, Eastern Europe, India and the Far East.



Figure 2b. A left AP carotid arteriogram in the venous phase, showing marked lateral displacement of the thalamostriate vein indicating severe hydrocephalus (arrows).

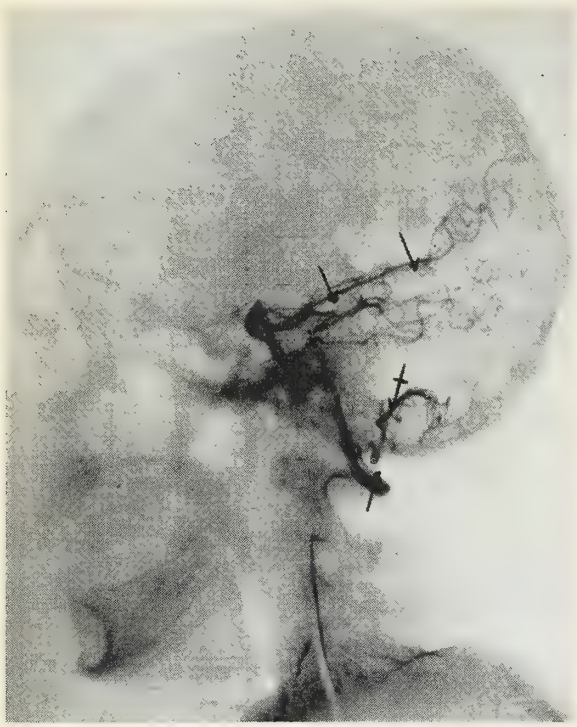


Figure 3. A left lateral vertebral angiogram, subtraction technique, demonstrates stretching of the posterior cerebral arteries and downward displacement of the supratonsilar portion of the posterior inferior cerebellar arteries (arrows). The choroidal artery is pushed down and forward (hatched arrow). These are indications of dilatation of the fourth ventricle.

Several published reports[3,4] indicate that as many as 25% of all patients in Mexico diagnosed as suffering from a space-occupying lesion in the CNS harbor the parasite while Stepien[5] reported that 1-2% of all admissions to a large neurosurgical center in Warsaw had cysticercosis. Consequently, a high index of suspicion must be kept in mind when patients present with CNS symptoms who have visited or immigrated from these areas.

Three Categories

Inside the CNS the parasite may present in several different ways. Stepien and Chorobski[6] divide patients into three separate clinical groups. The first is composed of patients in whom the cyst causes symptoms similar to any space-occupying intracranial tumor. Focal neurological deficits, seizures, cranial nerve dysfunction or obstructive hydrocephalus may result. The second group is comprised of patients with diffuse cerebral signs and symptoms of increased intracranial pressure. In these patients an "organic" type of mental syndrome with ataxia and rapid loss of vision occurs. This picture is seen most often in children and follows a fulminant clinical course. The third group consists of patients in whom the cysts locate mainly at the base of the brain causing a chronic basal leptomeningitis, internal hydrocephalus and variable focal signs. Mental disturbances may also be present. Presumably, the patient presented in this article falls into this category.

Treatment

There is no known medical treatment for cysticercosis cerebri. Steroids have been used and as in this patient may result in short term improvement, but long term efficacy is unknown. Depending on the presentation, the treatment is surgical when possible.

In the first group of patients, presenting with solitary lesions, reports have indicated an improvement or clinical recovery in 74%. In the second group improvement has been shown in 52% but carries a mortality rate of 33%. In the third group the prognosis is poor with clinical improvement in 28% and a surgical mortality of 63%. The latter group in which our case presents, may benefit from a palliative shunt to relieve the intracranial hypertension. Since a ventriculo-jugular shunt may result in hematogeneous spread, a ventriculo-peritoneal shunt was

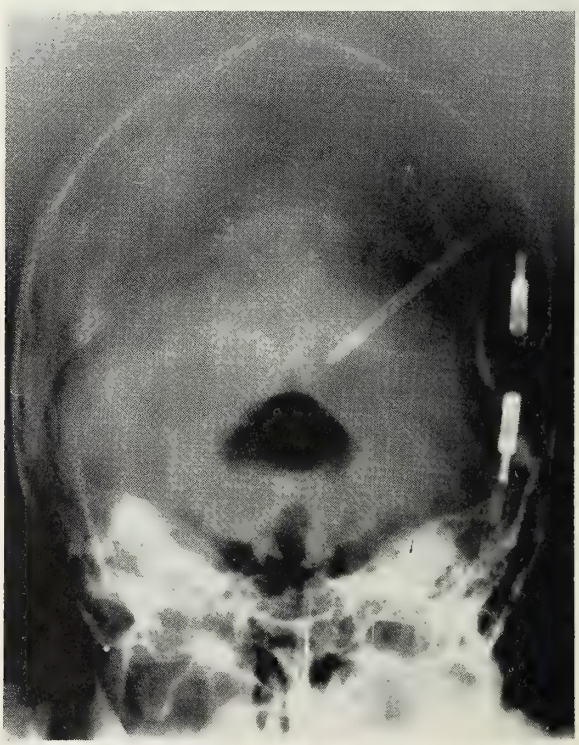


Figure 4. A pneumoencephalogram taken in the Town's position demonstrating marked dilatation of the aqueduct and fourth ventricle with no midline shift. A right sided Holter shunt is seen in position.

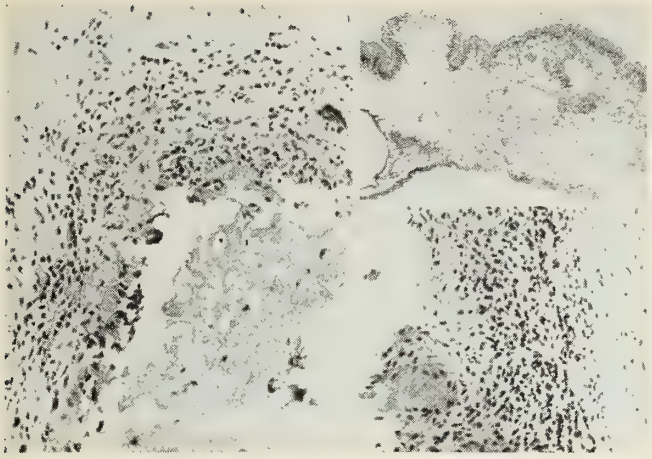


Figure 5. Typical granulomatous inflammatory response with few multinucleated giant cells is present (haematoxylin and eosin. X25). Upper insert reveals the characteristic three layered wall of the parasite (haematoxylin and eosin).

chosen as the procedure of choice. In this patient, both steroids and shunting resulted in symptomatic improvement, but over a period of several weeks the disease continued a relentless course. The removal of the cyst did not result in any improvement in the patient's condition.

Summary

The diagnosis of cysticercosis cerebri is a difficult one complicated by a variable incubation period and non-specific laboratory and diagnostic tests. A case is presented along with radiographs, pathological findings and surgical treatment. Ethnic background, past history and a high index of suspicion are essential aids for the diagnosis. ◄

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Pediatric Perplexites

(Continued from page 49)

Once the diagnosis of polycythemia is confirmed in infants with cardiovascular symptoms due to volume overload, a simple phlebotomy should be performed. The amount of blood to be removed may be decided using the following formula:

$$\text{Volume of exchange (ml)} = \text{Blood volume} \times \frac{\text{(observed hematocrit} - \text{desired hematocrit)}}{\text{Observed hematocrit}}$$

Blood volume of infant = 85 ml/kg body wt.

In asymptomatic infants and in infants without signs of volume overload the volume of blood removed is replaced with either colloid or salt poor albumin. The main problem in polycythemia is tissue hypoxia due to sluggish circulation which results from too many RBC's being tightly packed in the small vessels. This results in lack of space for the RBC to deform which is essential for its passage through the capillaries. Providing fluid space between erythrocytes permits deformability and permits perfusion.

Permanent central nervous system sequelae has been described in 22% of infants in the series reported by Gross.[3] In patient II, the finding of drooping of the angle of the mouth indicates possible central nervous system involvement. The long-term effects of the numerous seizures in this infant will be determined by follow up.

In Case I, maternofetal transfusion, the cause of polycythemia, was suggested by the elevated levels of hemoglobin A. In this infant, plasma sugar did not stabilize until after the phlebotomy. Our current philosophy is to treat immediately after the diagnosis is made.

A high index of suspicision and a routine hematocrit determination will enable early recognition of the problem. A simple procedure such as phlebotomy in most instances will prevent permanent central nervous system sequelae. ◄

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Megaloblastic Arrest in Hemolytic Anemia Due to Mycoplasma Pneumoniae Infection

By Juliet Melzer, M.D.; David Green, M.D., Ph.D.; Bryon S. Berlin, M.D.; and Simone Silberman, M.D./Chicago

Coombs-positive hemolytic anemias due to anti-I antibodies in the I-i red cell antigen system have been reported as a complication of Mycoplasma pneumoniae *infection. Although the anemia may be severe, improvement is usually rapid with subsidence of the infection.*

We wish to call attention to an important, life-threatening complication of this disorder. A previously healthy, 65-year-old woman presented with an acute illness characterized by a pulmonary infiltrate, hematocrit of 29, cold agglutinins in a titer of greater than 1:4096, and positive direct and indirect Coombs tests. A rising titer of antibody to M. pneumoniae *was demonstrated using the metabolic-inhibition test. The reticulocyte count was only 1%, and remained at this level for 72 hours, during which time the hematocrit dropped to 17, and the patient developed signs of congestive heart failure. A bone marrow examination revealed frank megaloblastosis. The serum folate was 5.8 ng per ml (normal: 5.9-16).*

The patient was treated with prednisone, erythromycin, a transfusion of 250 ml of washed packed red cells, and folic acid. Four days later her reticulocyte count began to rise and reached a maximum of 18% one week after the initiation of therapy. During the next 4 weeks, her hematocrit increased to 36 as the titer of antibody to I antigen decreased from 1:2000 to 1:20. This case indicates that Coombs-positive hemolytic anemia may be complicated by marrow failure secondary to megaloblastic arrest of erythropoiesis.

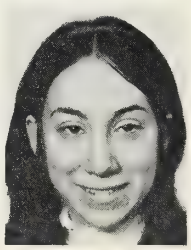
Acute hemolytic anemia has been reported in about 5 percent of cases of cold-agglutinin positive Mycoplasma pneumoniae lung infections.[1-3] The hemolytic process is due to interaction between the I antigen of the I-i blood group system and the anti-I cold agglutinin antibodies which arise during infection.[4] The I antigen is not found on fetal red cells but is acquired by 97 percent of adult red cells.[5] Hemolysis is usually self-limited and responds favorably to corticosteroid therapy. The present report describes an unusual case of M. pneumoniae infection in an elderly woman in whom the hemolytic anemia was complicated by megaloblastic arrest of the bone marrow, resulting in a precipitous fall in the hemoglobin and a near fatal outcome.

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Case Report

The patient, a previously healthy 65-year-old white female, entered Northwestern Memorial Hospital with a three week history of upper respiratory infection associated with a moderately productive cough. For two weeks prior to admission she had apparently eaten little solid food but instead nursed herself on honey and whiskey for relief of her cough. In the six days before admission she became mildly icteric and noticed progressive dizziness when standing. One day before entering the hospital she passed dark brown urine. The initial examination in the hospital showed a temperature of 101.2° F, pulse of 110 per minute with 12 premature beats per minute, and a blood pressure of 130/70 supine and 80 systolic standing. The patient's breathing

was labored, and she showed mild scleral and palatal icterus. Her cardiac examination was normal, but her pulmonary examination revealed coarse inspiratory rales and bronchophony at the right lung base. Her spleen was not palpable.

The chest X-ray obtained on admission showed a hazy shadow in the right lower lobe of the lung. Cultures of the sputum for bacterial pathogens, viruses and fungi were negative. Her white blood cell count on entering the hospital was 18,700/mm^3 with 77% segmented cells, 2% bands, 1% basophils, 16% lymphocytes, 4% monocytes, and 1 nucleated red cell/100 WBC. Laboratory examination showed a hematocrit of 29, a hemoglobin of 10.6 g/100 ml and 1% reticulocytes. The platelet count was 397,000/mm^3. The urine urobilinogen was 0.9 Ehrlich units, and the serum bilirubin was 3.5 mg/100 ml total (0.3 mg/100 ml direct reacting). The serum LDH was 640 units (heat stable fraction, 110 units), and the plasma haptoglobin was 140 mg/100 ml. Both direct and indirect Coombs tests were positive. Hemoglobin electrophoresis revealed 100% hemoglobin A. The titer of cold agglutinins was greater than 1:4096 (the highest serum dilution tested), and at room temperature a precipitate formed in the plasma. Serum immunoglobulin levels were: lgG 1000 mg/100 ml, lgA 190 mg/100 ml, lgM 200 mg/100 ml and lgD 6 mg/100 ml.

Course of Hospitalization

The patient's illness was diagnosed on admission as a bacterial pneumonia and she was initially treated with 600,000 units of procaine penicillin intramuscularly every 12 hours. When the high level of cold agglutinins was reported on the third hospital day, the penicillin was stopped and treatment with erythromycin, 500 mg every six hours, was started. However, by this time, the hematocrit had fallen to 17, the hemoglobin to 6.1 g/100 ml, and the reticulocytes remained at 1% (figure 1). The peripheral smear revealed red cell agglutination, macrocytosis, spherocytosis, and occasional atypical lymphocytes. A bone marrow aspirate was hypercellular with a myeloid to erythroid ratio of 1:1. Erythropoiesis was megaloblastic, and giant bands and metamyelocytes were observed. Serum folate concentration was 5.8 ng/ml (normal, 5.9 to 16.0 ng/ml), and the serum B_{12} level was 605 pg/ml (normal, 400-800 pg/ml). Therapy with folic acid, 5 mg t.i.d. and prednisone, 15 mg q.i.d. was started.

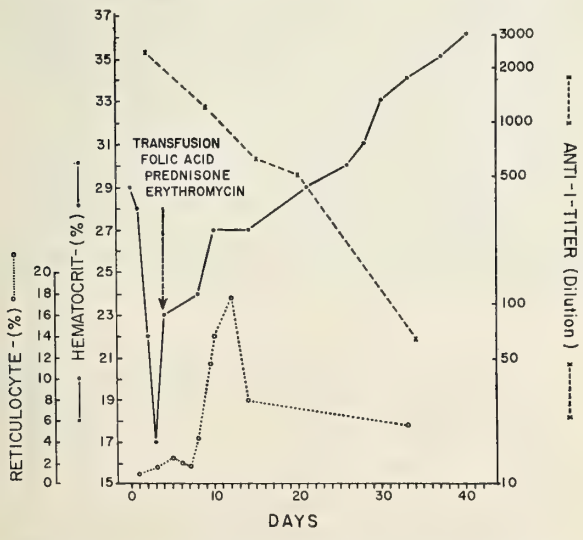


Figure 1. Changes in hematocrit and reticulocyte count before and after therapy. Note the relationship between rising hematocrit and falling anti-I titer.

By the fourth hospital day, there was clinical evidence of congestive heart failure. An apical systolic murmur was noted, and a soft spleen was just palpable at the left costal margin. It was apparent that red cell transfusion was indicated, but the patient's serum agglutinated all available banked cells. Therefore, the patient's serum was diluted, and the donor cells showing the least agglutination with this diluted serum were warmed to 37° C and slowly transfused (250 ml).[6] Following this transfusion, the hematocrit increased to 23 (Fig. 1), and the patient's general condition stabilized. Reticulocytosis became evident on the eighth hospital day (four days after initiating folic acid therapy), and reached a maximum of 17.6% on the twelfth hospital day.

The patient became afebrile by the twelfth hospital day, and her chest X-ray showed clearing of the right lower lobe infiltrate. Erythromycin was discontinued at this time. A metabolic inhibition test for antibody against Mycoplasma pneumoniae was positive at titers of 1:20 and 1:1280 with sera obtained on the second and thirteenth days of hospitalization, respectively. Complement-fixation titers against M. pneumoniae antigen with these sera failed to show antibody at dilutions of 1:10 or greater.

Five weeks after admission, the hematocrit was 34 and the hemoglobin, 11.5 g/100 ml. The Coombs test was negative, and the LDH, 480 units. Cold agglutinins were still positive in a titer of 1:512. A Cr^{51} red cell survival study completed at this time showed a red cell half-life of 20 days, with no evidence of sequestration by liver or spleen. The prednisone dosage was gradually reduced and the patient discharged on the forty-first hospital day. By six months after admission, all medications had been discontinued, and the patient had a normal blood count.

Table 1
Serial Titrations of the Patient's Serum Against Adult Cells (0, I), Cord Cells (0, cord), and Adult I-Negative Cells (0, i)

Type of Cell	Day of Hospitalization					
	2	9	15	20	34	54
0, I	2520*	1260	640	512	64	32
0, cord	640	320	320	256	32	—
0, i	40	80	40	—	—	—

**Titer expressed as reciprocal dilutions*

Special Studies

The patient was blood group A, Rh +. Preliminary tests on her serum showed a high titer of cold agglutinating antibody. The serum reacted with all erythrocytes of a commercial panel*, as well as the patient's own cells, with equal strength. The undiluted serum obtained on the second hospital day reacted with cells equally at 4° C, 18° C, and 23° C. There was no agglutination at 37° C, but a weak reaction was observed following the addition of antiglobulin serum. The cold auto-antibody was characteristic of anti-I as shown by the strong reaction with adult red cells which carry the I surface antigen and the weaker reactions with umbilical cord red cells and I-negative (i) adult red cells. During the course of the patient's illness, a number of titrations of the cold auto-agglutinin were performed, the results of which are shown in Table 1. All sera dilutions and cell suspensions were made in saline, and testing was performed at 4° C.

Discussion

The patient described in the present report demonstrates that maturation arrest of erythropoiesis and reticulocytopenia can occur in cold agglutinin-positive M. pneumoniae infections in man. Previously, these phenomena were seen mainly in patients with chronic hemolytic disease such as hereditary spherocytosis and sickle cell disease. Such patients usually have chronically low serum folate levels and diminished folic acid stores. During periods of active hemolysis, adequate folic acid stores are needed to meet the increased demands of the bone marrow for greater nucleic acid synthesis and increased production of erythrocytes. The association of aplastic crisis and megaloblastic anemia with infection has suggested that the infectious process may either be a direct cause of hemolysis, may result in the inability of the bone marrow to compensate for hemolysis, or may act directly as a folic acid antagonist.

Treatment has been by transfusion and oral folate preparations.[7-14] It should be emphasized that in patients with cold hemolysins, warming of the blood to 37° C prior to transfusion is essential in preventing agglutination of the transfused cells.[1-3] The response of our patient to this therapy was demonstrated by an immediate increase in hematocrit following the transfusion, and a reticulocytosis which first became evident on the fourth day after starting folate therapy and reached a peak on the eighth day. The hematocrit progressively rose as the titer of anti-I antibody declined.

**Panocell, Panel No. 1133, Pfizer Inc., Groton Conn.*

In our patient, cold agglutinins were found in the highest titer when the hemolytic anemia was most severe. They were demonstrated by the ability of the patient's serum to produce maximum agglutination of adult I antigen positive red cells at 4° C. Our patient also had low levels of an antibody that reacted with I antigen negative (i) fetal red cells (Table 1). Titers of this antibody decreased in parallel with the anti-I antibody levels. The actual diagnosis of M. pneumoniae infection was based on the demonstration of a significant increase in the titers of metabolic-inhibition antibody in acute and convalescent sera. Complement-fixing antibodies, though absent in our patient, have been reported in approximately 85 percent of patients with this disease.[15] Thus, the recognition of these several distinctive antibodies plays an important role in the diagnosis of M. pneumoniae infections.

Conclusion

The development of marrow failure in our patient is explained by the activity of the hemolytic anemia and the patient's history of poor dietary intake, a common occurrence in older people. Although most patients with cold agglutinin-positive mycoplasma pneumonia are predisposed to folate deficiency, the severity of the complication observed in this patient is unusual. However, it raises the question of whether milder forms or marrow failure may escape detection. Determination of folate levels in patients with viral pneumonia and acute hemolytic anemia, especially the elderly, should indicate which patients would benefit from prophylactic therapy with folic acid. Such treatment, continued during the course of the acute infection, might prevent the insidious development of marrow failure and the necessity for providing transfusions to patients with circulating red-cell antibodies. ◄

Acknowledgments

We wish to thank Mr. Earle Edwards of Naval Medical Research Unit No. 4, Great Lakes, Illinois for performing the metabolic-inhibition test for antibody to M. pneumoniae, and Dr. Kenneth Campione for his kind assistance in the investigation of his patient.

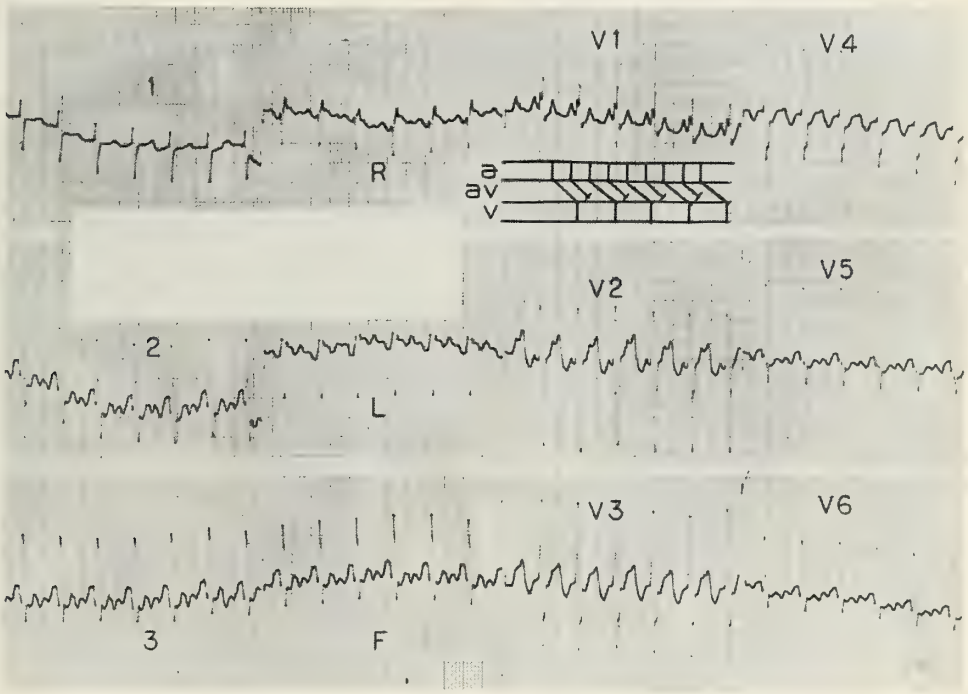
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A complete bibliography for "Megaloblastic Arrest in Hemolytic Anemia" may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe St., Suite 3510, Chicago 60603.

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A twenty-two year old woman presented with complaints of easy fatigability and palpitations. This had been worsening over the previous several months. She denied any chest pain and had no trouble sleeping. The episodes of palpitations were becoming more frequent and lasting much longer. Her physical exam was abnormal because of a marked left sternal border lift, fixed splitting of the second heart sound, and a grade 3/6 ejection systolic murmur heard best along the left sternal border. Her heart rate was 150 beats per minute. This 12 lead ECG was taken:



Questions:

1. The 12 lead ECG shows:
- A. Atrial tachycardia.
- B. Atrial flutter.
- C. Right ventricular hypertrophy.
- D. Left ventricular hypertrophy.
- E. Right axis deviation.

2. The following statements are true:
- A. Treatment could be digitalis.
- B. Atrial flutter is usually associated with heart disease of some type.
- C. The prognosis of this patient would be related to the underlying heart disease.
- D. Direct current countershock can be good therapy.
- E. Quinidine alone in this situation could be dangerous.

(Answers on page 61)

*Treatment and Referral of Patients Presenting with Sexual Dysfunctions**

By Leo I. Jacobs, M.D./Des Plaines

The physician is still regarded as the expert on human sexuality by the overwhelming majority of the population even though he frequently may be ill-prepared for such a role because of deficiencies in his medical training, personality traits, or personal life experiences. A physician's therapeutic effectiveness in treating sexual problems is determined by several factors.

First the physician's attitudes regarding his own sexuality and the different variants of human sexual behavior affect the doctor's ability to treat sexual problems. Discomfort with sexual topics as evidenced by blushing, fidgeting, changing the subject, anger or uneasiness discourages a patient who is often ridden with shame or guilt from talking freely. The patient's discomfort in tackling sexual matters quickly vanishes when the physician uses the same objective, thorough and matter-of-fact approach in taking a sexual anamnesis as he does in pursuing other aspects of the medical history. A physician's discomfort may reflect his defensiveness about a possible personal sexual problem, his feelings of being therapeutically ineffective or his fear of being erroneously accused of a sexual interest in the patient. A physician can become aware of such counterproductive attitudes by monitoring his own subjective reactions for signs of anxiety or anger while approaching sexual topics with the patient. Another evidence of such negative attitudes is a tendency to label certain sexual practices as "abnormal" without an awareness of the danger to masquerade deviations from religious or moral norms as deviations from a statistical or physiologic norm.

Secondly a physician may be hindered in the treatment of sexual problems by his knowledge of sexual behavior in its physiologic and psychosocial aspects. Thirdly, the physicians's ability to counsel patients while maintaining a doctor-patient relationship that fosters understanding and self-reliance in the patient must also be considered.

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Four Tasks

The physician's first task is, of course, to rule out organicity on the basis of a thorough history, physical exam and appropriate tests.

Next, he is in a pivotal position as an authoritative and respected professional, to allay irrational fears and correct sexual problems based on ignorance or incomplete and erroneous information. He can be especially helpful in debunking numerous disruptive sexual myths by pointing out:

a) the importance of non-genital tenderness in the male's sexual approach to the female which she usually prefers to copulatory adroitness;
b) the sexual responsiveness of the mate as an important source of arousal;
c) the often irritating effect of direct clitoral stimulation;
d) the fallacious definition of masculinity as genital prowess combined with an inborn omniscient knowledge of female sexuality in the male;
e) the need for the male to receive verbal feedback and instructions from the female so that he can truly pleasure her; and,
f) the importance of the male being vocal and verbal while experiencing sexual pleasure or having an ejaculation so that his mate gets behavioral, rather than just verbal encouragement to become uninhibited.

A third task is to make an evaluation of the patient's mental status, not only to rule out a significant psychiatric disorder, but also to evaluate the level and sources of his self-esteem. A psychiatric referral is usually in order not only when the patient has a severe neurotic or psychotic problem, but also when he has an extremely low sense of self-worth, is excessively dependent on others' compliments or opinions to feel good about himself, and shows signs of depression such as insomnia, pronounced indecisiveness and sadness, with the sexual problem as the focal

point of a general subjective sense of psychological impotence.

Fourthly, the patient's spouse or mate should be included in the evaluation process as well as the counseling sessions. A sexual problem always reflects as well as affects the relationship in which the sexual interaction occurs. If the couple shows signs of severe interpersonal strife such as chronic resentment, mutual disinterest, and feelings that the mate cannot change, distorted or severely impaired communication, an unwillingness to terminate an affair with a third person and an obsessive interest in proving to the physician that the mate is "sick" or entirely to blame for the problem, a referral to a mental health professional who specializes in conjoint therapy, is indicated.

To use simple instructions or counseling with such disenchanted couples, will either be ineffective, or, if successful in removing the sexual problem, may trigger a serious disruption in the interpersonal homeostasis often resulting in severe psychiatric problems such as depressions or psychotic episodes in genetically predisposed individuals. Psychotherapy addressing itself to the unconscious factors of a relationship is indicated rather than counseling. Psychoanalytically speaking, the sexual problem of the one partner may represent the unacceptable self of the "well" partner who is "addicted" to the inadequacies of the mate to generate adequate self-esteem for himself or herself.

If however, the relationship is based on a predominantly positive commitment to each other, with a willingness to change the sexual, as well as the non-sexual aspects of their behavior, we are usually dealing with a fear of failure, feelings of shame or guilt, and ignorance or misinformation which are very amenable to short-term counseling.

Treatment of Impotence

The physician has to rule out organicity especially vascular, endocrine, neurological, and genetic factors. Impotence may be the first symptom of a diabetic visceral neuropathy. It may be a sign of an undiagnosed Klinefelter's syndrome. The patient's use of drugs must be explored as a cause of impotence. Depression may also cause impotence. It may be a form of pathological mourning in widowers or divorced men starting a new relationship with a woman.

The presence of occasional morning erections coinciding with the last REM period of the night, the achievement of erections for masturbatory purposes or successful extramarital coitus clearly indicates a psychogenic etiology for impotence.

Primary impotence usually stems from severe negative psychogenic influences requiring psychiatric interventions. Here we deal mainly with a perception of women as phobic objects based on adverse maternal influences, serious deficits in male identity, homosexual orientation disturbances or extreme religious orthodoxy.

Secondary impotence following periods of successful coital functioning is usually based on a pronounced fear of failure. Occasional sexual failures after alcohol abuse or a particularly tiresome day become engrained as a sexual dysfunction because the fear of failure turns the male from a participant in pleasurable sexual activities into an anxious observer who sets out to achieve the impossible: namely to will an erection. The physician should indicate to the couple that this is as impossible as it is for a woman to will vaginal lubrication.

The physician should be aware of two factors that increase the fear of failure: a) the male's tendency to base his whole sense of self worth on how firm and quick his erections are; b) the female's tendency to misinterpret her husband's impotence as a proof that she is undesirable.

The physician can help a couple presenting with secondary impotence by the following interventions:

a) by prohibiting sexual intercourse for two weeks and by instructing the couple to give each other on alternate occasions, body caresses, excluding the genitals during the first week. The sensuousness of this non-demand sensate focus exercise removes the fear of failure. The best position for direct genital stimulation is for the female to be astride the man. At no point is coitus the goal. She stimulates the penis to erection, caresses other areas of the body, then restimulates the penis in a teasing fashion until the husband is reassured that he is potent. The next step is the insertion of the erect penis by the female, for an experience of genital merger without demand for actual intravaginal ejaculation. Finally, the couple after two weeks proceeds to intercourse while the female in the superior position makes slow pelvic thrusting movements.

b) by encouraging the couple to explicitly state their sexual needs so that the husband may satisfy her in other ways than sexual intercourse such as manual or oral stimula-

tion. Having other techniques at his disposal will further reduce his fear of failing.

c) by prescribing a minor tranquilizer such as 5 mg. of Valium, to be taken by the husband, one hour before the couple starts their sexual interacting to reduce his anxiety.

d) by encouraging the husband to be more self-assertive vis-a-vis his wife who is usually rather controlling in a maternal fashion. This may help him to express his anger more directly and verbally, rather than indirectly through impotence.

A psychiatric referral is indicated when the physician does not find the typical marital pattern of a passive-dependent husband and a controlling wife. In some cases of secondary impotence the husband is rather grandiose in his self-concept and is married to a woman who has become more competent and self-confident in the course of the marriage, and who no longer worships him as she did in the beginning of the marriage.

In other cases the impotence developed in the husband while his wife became increasingly more depressed with pronounced feelings of inadequacy. These two marital patterns require psychiatric intervention because the impotence plays a crucial role in maintaining a precarious marital homeostasis.

Premature Ejaculation

This dysfunction results mainly from conditioning such as rapid and furtive petting in lovers' lanes. It can be corrected through a retraining process requiring the cooperation of the partner. If properly carried out, this technique is 99% effective.

In the squeeze technique the female is astride her husband who is recumbent. She is instructed to stimulate the penis to erection until ejaculation is imminent, then place both thumbs on the frenulum and the first fingers of both hands on the superior aspect of the coronal ridge, and exert pressure for 20 seconds. The ejaculation is avoided and the erection subsides partially. The husband has to indicate, verbally or through a gesture, when he is about to reach the point of ejaculatory inevitability.

This procedure is repeated twice and for the third time, the manual stimulation is continued until the male ejaculates. This whole process is repeated twice during the first week.

During the second week, the female is instructed to stuff the limp or semi-erect penis in her vagina, and thrust slowly until the point of ejaculatory inevitability is reached. She then removes the penis from the vagina, and applies the squeeze. This procedure is also repeated twice, and for the third time, the penis is removed from the vagina for ejaculation. This whole process is repeated twice during the second week.

During the third week, the couple resumes sexual intercourse. During the first two weeks, the husband is instructed to give his mate a general body caress including stimulation of her genitals to the point of orgasm.

This dysfunction occurs frequently in a marriage between an obsessive-compulsive husband preoccupied with performance, and a hysterical wife who many times harbors resentment at him for being too mechanical in his sexual approach. To instruct him to express his affection more tenderly, helps his wife to become less angry and therefore more consistently orgasmic.

Ejaculatory Incompetence

In my clinical practice, I encounter one case of such inability to terminate coitus with an intravaginal ejaculation, for every 10 cases of premature ejaculation. It is important that the physician evaluate this patient psychiatrically. If he is paranoid, extremely sensitive regarding his masculinity, and relates a history of being raised by a mother combining extreme sexual inhibitions with seductiveness (checking sheets for sperm stains or bathing teenage son), psychiatric referral is in order.

If not, the partner is instructed to manipulate the penis while asking for precise directions to increase the pleasure of manual stimulation. Such stimulation is continued until extra-vaginal ejaculation is accomplished. This is very crucial as it helps associate his wife and ejaculatory release within the mind of the patient. Once ejaculation has been achieved, in previous sessions, through manual stimulation, intermission is effected by the female as soon as ejaculation becomes imminent. She thrusts demandingly while using the female superior position.

Orgasmic Dysfunction in the Female

Many women who cannot achieve orgasm because of a very sexually restrictive upbringing continue to be inorgasmic because of certain marriage conditions related to their repressed or suppressed resentments. They harbor anger at their husband for not being emotionally available in the relationship or being exclusively genital, mechanical, and lacking in tenderness during sexual intercourse. To treat this dysfunction

without including him in counseling, is impossible. The physician can be effective in treatment of this dysfunction in the following ways:

a) by doing a pelvic examination in the presence of the husband and instruct him on the anatomy of his wife's genitals, especially the location and function of the clitoris.
b) by pointing out to the husband that his wife will have to instruct him on how to pleasure her through verbal feedback or through direct manual guidance (placing her hand over his), and that he should not take such directions as criticisms.
c) by emphasizing to the husband, the importance of gentleness and tenderness in bed, and the need for him to be emotionally involved with her outside of bed (spend more time with her, express affection outside of sexual interactions).
d) by instructing his wife to explore her own genitals visually (with a mirror) or tactilely. If she has no significant guilt or moral objections he can tell her to proceed on to self-stimulation so that by having improved her knowledge of her own body's responsiveness, she is in a better position to teach her husband to pleasure her.
e) by stressing to the husband that a direct clitoral approach can be more irritating than arousing. Manipulation of the general mons area, particularly the clitoral shaft, the inner thighs and labia can be most arousing. The husband can alternate stroking of other body areas with the caresses of the genitals.
f) by instructing the couple that once manual genital excitation is successful, coitus can be engaged in, using the female superior position. The wife moves slowly while the husband lies still and does not make any demands. She should focus her attention on vaginal sensations.
g) by instructing the couple to alternate manual genital stimulation with episodes of genital merger: penetration followed by minimal pelvic thrusting with no attempt to achieve orgasm or intra-vaginal ejaculation. It is an experience of closeness, intimacy, and union.
h) by instructing the husband to thrust nondemandingly at a pace communicated by the wife, once she has developed vaginal sensations.

The crucial elements to be attained in successful counseling are an increase in communication, a genuine effort of the husband to become more emotionally expressive with his wife, and mutual understanding that an orgasm is not a goal to be pursued, but an unintentional by-product of a mutual pleasure experience.

If the physician finds that the inorgasmic female is married to an extremely passive man, has a history of being raised by a resented mother, and a very seductive, sadistic or cruel father, and is extremely nagging with her husband, psychiatric referral is in order.

The physician can set aside three to four half hour sessions with the couple, to achieve the above described objectives in treating the different sexual dysfunctions. The sessions are scheduled over a period of one to three months. If the couple shows strong resistance to carrying out instructions, or fails to improve after three months, psychiatric referral or consultation may be in order. ◄

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EKG

(Continued from page 57)

Answers: 1. B,C,E 2. All

The atrial rate is slightly greater than 300 beats per minute and is conducted with a 2:1 atrioventricular block. This is atrial flutter. The "f" waves of atrial flutter can best be seen in leads V_1, II, III, and avF. There is a tall R wave in lead V_1, and the R/S ratio is greater than 1, criteria for right ventricular hypertrophy. The QRS axis in the limb leads is rightward to approximately $+115°$. The classic treatment for atrial flutter is digitalis although direct current cardioversion is also useful. This arrhythmia is almost always associated with organic heart disease. In this case the patient had an atrial septal defect with a 3:1 left to right shunt at the time of cardiac catheterization. The defect was closed surgically and the patient has been in sinus rhythm since then on digitalis. Quinidine alone can depress the atrial flutter rate and bring it down to a range that the AV node can more easily conduct on a 1:1 basis. This paradoxical facilitation of the ventricular rate in atrial flutter can result in the absence of digitalis and is due in part to the vagolytic effect of quinidine.

Subacute Pyogenic Osteomyelitis of the Thoracic Spine Diagnosed by Gallium Scan

By Michael Goldberg, M.D., Eugene Balthazar, M.D., and
Ronald Lee Nichols, M.D., M.S./Chicago

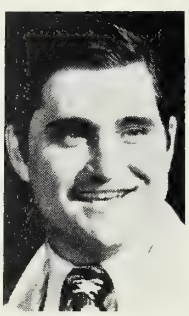
Although it is not rare, subacute pyogenic osteomyelitis of the spine is a rather uncommon entity,[1-3] *accounting for about 4 percent of all casess of osteomyelitis.*[3] *Its insidious course and confusing symptoms frequently lead to delays and errors in diagnosis.* [1-6] *Recently, many papers have been published concerning the localization of septic lesions by gallium*[67] *citrate scanning.*[7-11] *The following case demonstrates the confusing nature of pyogenic osteomyelitis of the spine and its diagnosis by the gallium scan technique.*

Case Report

This was the first admission to V.A. West Side Hospital for this fifty-three-year old white male whose chief complaint was left upper quadrant abdominal pain, left flank pain, and intermittent fever of four months' duration. The patient reported that he had been in good health until December, 1973, when he fell down his basement stairs. After this accident, the patient immediately complained of mild back pain; but he sought no medical attention until twenty-four hours later when he developed left flank tenderness, fever, and chills. The patient's physician examined him and gave him an injection of penicillin. Four days later, the patient was still symptomatic. He was admitted to a local hospital, where he was found to have mild left flank tenderness and a temperature of 100°F. His complete blood count (CBC) and urinalysis at that time were within normal limits. A chest X-ray revealed mild atelectatic and pneumonic changes in the left lower lobe of the lung. The fifth rib on the right and the ninth rib on the left were fractured. Further work-up included an intravenous pyelogram (IVP), which revealed a double right collecting system and the absence of any other abnormality. Cystoscopy and retrograde urethrogram were performed which confirmed the results of the IVP. An upper gastrointestinal X-ray series was reported as normal. The patient was treated with tetracycline and analgesics. After ten days he was afebrile and returned home to convalesce.



MICHAEL GOLDBERG, M.D. graduated from the University of Illinois, Abraham Lincoln School of Medicine in June. He had an Illinois State Scholarship and was a member of AOA, Phi Beta Kappa, and Alpha Epsilon Delta.



RONALD LEE NICHOLS, M.D., M.S. is an Assistant Professor of Surgery at the University Health Sciences/The Chicago Medical School and attending surgeon at the VA Hospital, Downey. He is also on the Executive Board for Westminister House in Chicago and received the Medical Student Council House Staff Award for Teaching in 1972.

EUGENE BALTHAZAR, M.D. is a Surgical Resident in the University of Illinois Metropolitan Group Affiliated Hospitals, MacNeal Memorial Hospital, Berwyn. He graduated from University of Illinois, Abraham Lincoln School of Medicine.

In January, 1974, the patient attempted to resume his work as a carpenter, but he was forced to quit because of increasing left flank pain. He again consulted his physician, who treated him with analgesics. In March, pain still prevented the patient from working. He was intermittently febrile and was losing weight. He therefore returned to his local hospital but was soon discharged with no further diagnosis.

Final Course of Disease

Shortly after this discharge, the patient was febrile almost daily and began to have constant, severe left flank and left upper quadrant pains which increased with movement and slightly decreased with analgesics, rest, and heat. He was admitted to the Surgical Service of the West Side Veterans Administration Hospital with a temperature of 104°F, chills, and diaphoresis. Physical examination was negative except for a grade II/VI systolic ejection murmur. Hypoactive bowel sounds, and left flank and upper quadrant tenderness with voluntary guarding. The urinalysis was within normal limits, the

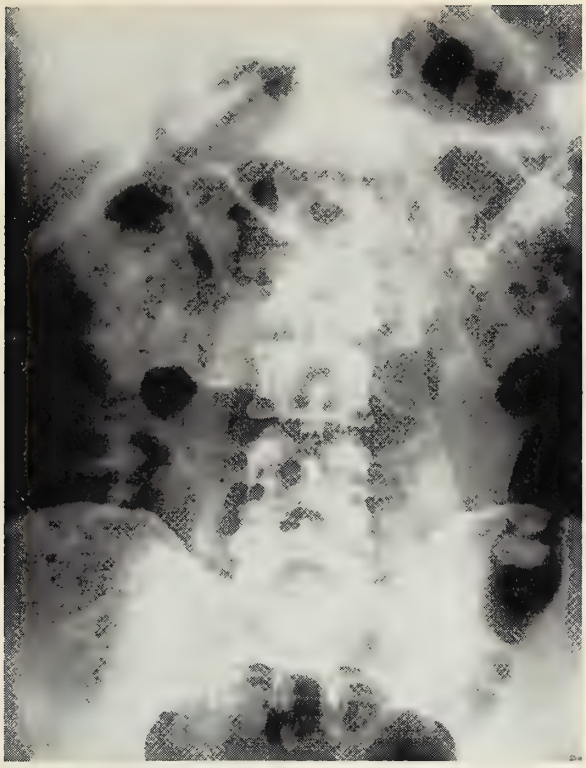


Figure 1. Abdominal flat plate taken at the time of hospital admission. A paralytic ileus pattern is noted with air being located in stomach, small bowel, and colon.

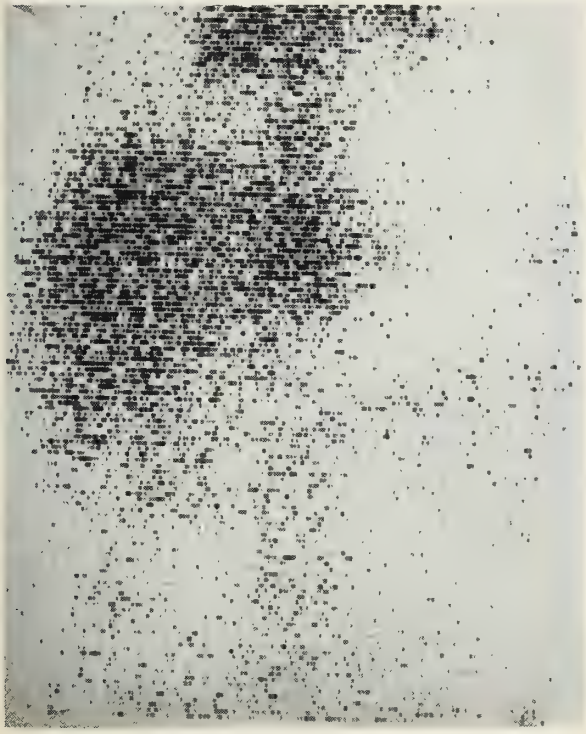


Figure 2. Gallium scan of anterior aspect of trunk showing normal uptake in liver and vertebral column. No areas of increased uptake are seen.

white blood count was 7,900, the hemoglobin was 11.3, and the sedimentation rate was sixty-five.

The chest X-ray on admission showed an old fracture of the fifth rib on the right and the ninth rib on the left and atelectasis of the left lower lobe. A flat plate of the abdomen demonstrated a paralytic ileus (Fig. 1): an emergency IVP and UGI were basically negative, except for the aforementioned kidney abnormality. An X-ray of the spine showed no abnormality. A liver-spleen scan revealed a normal liver and a slightly enlarged spleen. Six blood cultures drawn from different sites at different times all

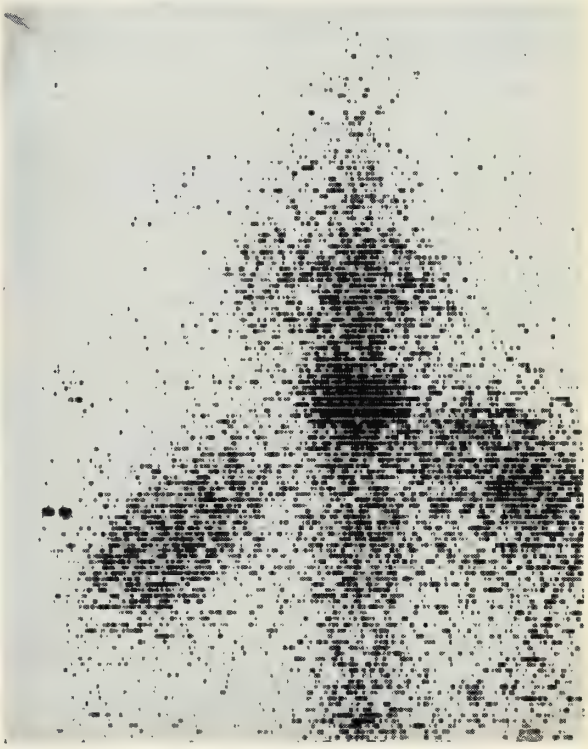


Figure 3. Gallium scan of posterior aspect of body showing normal uptake in the spleen and liver with a "hot" spot located in the middle of the vertebral column corresponding to T_8-T_9.

produced growth of penicillin-resistant Staphylococcus aureus. A bone marrow examination showed myeloid hyperplasia and slight plasmacytosis. A second strength PPD test was negative at forty-eight hours.

The patient was intravenously injected with 600 milligrams of clindamycin exery six hours, and the fever disappeared in three days; however, the source of the infection was still unidentified. A perinephric abscess or a splenic abscess had been ruled out, but other retroperitoneal or subdiaphragmatic abscesses were still



Figure 4. A-P laminogram of thoracic spine showing rarefaction in the bodies of T_8 and T_9 and associated left sided paravertebral abscess.

highly suspected. We therefore decided to use a gallium scan to determine the diagnosis. Five days after gallium[67] citrate was injected intravenously, scanning revealed a normal anterior view (Fig. 2) and a hot spot posteriorly in the mediastinum in the area of the thoracic spine. (Fig. 3). Tomographs of the thoracic spine revealed a paravertebral abscess and an area of rarefaction in the bodies of the eighth and ninth thoracic vertebrae adjacent to the intervertebral space (Figs. 4 and 5).

Based on the clinical course, the positive gallium scan, the bacteriologic studies, and the X-ray findings, the diagnosis was determined to be subacute pyogenic osteomyelitis of the spine. The patient was then transferred to the Orthopaedic Section and treated with antibiotics and a back brace. He was subsequently discharged from the hospital with a Jewlett back brace and was treated with decreasing oral doses of clindamycin over a six-month period. Two months after discharge, the patient was reportedly free of pain, gaining weight, and planning to return to work.

Discussion

This case illustrates many features that are typical of pyogenic osteomyelitis of the spine. The initial complaint was back pain, a characteristic complaint that is the most common symptom of the disease. [1,4] In patients in whom the cervical, thoraco-lumbar, and lumbar regions of the spine are affected, diagnosis is usually based on the pain, spasm, and rigidity of these areas. However, in those in whom the more immobile region of the thoracic spine is affected, these symptoms are almost nonexistent[5] and are overshadowed by the severe, unremitting nerve-root pain, which occurs in most cases of pyogenic osteomyelitis of the spine.[1,3,4] As in this case, the white blood count is usually normal and the ESR is invariably increased.[1-6,12] In this case, the infecting organism was isolated from the blood; but more often the blood is sterile and direct or indirect vertebral body biopsy is the only alternative for positive identification of the organism.[1,3]

X-ray in this case was very helpful in establishing the diagnosis and the findings were typical of vertebral osteomyelitis. Early in the disease, paravertebral shadows may increase due to edema, osteal calcification, local destructive vertebral body changes, alteration of the intervertebral spaces, diverse proliferative changes with varying degrees of erosive and destructive phenomena, and new bone formation.[2] The gallium scan, which led to the tomographic studies of the thoracic area, has not yet been reported for the diagnosis of osteomyelitis of the spine; however, numerous reports have appeared in the literature that attest to its efficacy in the localization of other septic lesions.[7-11]



Figure 5. Lateral laminogram of thoracic spine showing lesion primarily involving the anterior aspects of T_8-T_9 and the associated intervertebral space.

The pathogenesis in this case was somewhat obscure. Staphylococcus aureus was the etiologic agent as determined by blood cultures; indeed, many reports document S. aureus as the organism most often isolated from these lesions.[2,4-6] Commonly, there has been a history of urinary tract manipulation, but such cases are usually associated with gram-negative organisms.[4] Other portals of entry include furuncles, carbuncles, and direct puncture injuries, none of which were found in this patient. A four-month delay in diagnosis from the onset of symptoms is a common experience in cases of subacute vertebral osteomyelitis.[1,3,4,12] The conservative management, such as this patient received, is the treatment of choice and usually results in spontaneous fusion of the affected area within one to two years.[1,3-5] ◄

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Bacterial Endocarditis

(Continued from page 39)

gery has been suggested, particularly when the infection cannot be controlled with vigorous antibiotic therapy and when the patient develops serious congestive heart failure.

In our case a ventricular septal defect murmur developed. This was probably due to the Bacillus subtilis endocarditis which in turn caused the teflon patch to open. Congestive heart failure did not develop. In our patient the infection fortunately was controlled with antibiotic therapy. ◄

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Medical Legal Review

(Continued from page 41)

must be found to give protection to the young physician just entering practice who has no assets and is unable to afford the astronomic malpractice insurance premiums now being charged to some medical specialty practices. The alternative is early retirement of physicians who may be in their professional prime; or the avoidance of certain specialty practice modes by the beginning physician. In either case, the patient and the community suffers.

10. We believe that the general field of Legal Medicine is a highly specialized one, for both the physician and the attorney. The complex, technical problems that are present in even the most obvious case alleging professional liability are such that true justice demands a tribunal, and the actors therein must be of the highest competence and expertise. We therefore believe that the establishment of specialty courts, of the type found in the fields of admiralty, patent law, tax law, and probate and divorce law, is highly desirable.

In conclusion, we believe that the present situation in the general field of medical malpractice or professional liability litigation is no longer tolerable. We believe that this is a community problem of oppressive magnitude that cannot be solved without the good will and intelligent contributions of the entire community. We would welcome the initiative of the Bar in finding and implementing solutions. We look to the legislature as the ultimate source of relief. We caution the Bar, the Legislature, and the community at large, that the time is late; the situation is serious and perhaps critical; and solutions must not be delayed. ◄

Doctor's News

SOME HOSPITALS IN TROUBLE?—Three years ago Congress approved an action giving the U.S. Department of Health, Education, and Welfare power to perform "validation review" inspections on hospitals already certified by the Joint Commission on Accreditation of Hospitals. Thus, at random, the Government selected 144 hospitals for inspection and failed 105 of them. In Illinois nine out of thirteen hospitals inspected lost their validation. It might seem to be that the Federal Government is trying to take control of the JCAH's job, a bureaucratic dream with thousands of inspectors, clerical assistants, reports, surveys, studies, and so on; all to be supported by taxpayers and patients.

MALPRACTICE INSURANCE FOR CLINICS—While personal and hospital coverage for professional liability is of paramount concern presently, a new threat has come up. If clinics, blood banks, or other providers are having difficulty with basic or excess coverage, contact should be made immediately with the State Director of Insurance, Robert Wilcox, explaining the problem and its ramifications. He may be addressed at: 160 N. LaSalle, Room 1660, Chicago.

SIU MEDICAL SCHOOL GRADUATES FIRST CLASS—The first graduating class of Southern Illinois University School of Medicine received their Doctor of Medicine degrees June 8, in the rotunda of the State Capitol Building. This historic class of 24 and their future colleagues are in part answering the manpower need recognized by the Illinois General Assembly in 1965, which led to legislation creating the state's second public medical school.

The traditional hooding of graduates gave special recognition to **Martin Van Brown, M.D.**, President of the SIU Board of Trustees during the early growth of the School of Medicine. Also honored were **James Campbell, M.D.**, President of Rush-Presbyterian-St. Luke's and former chairman of the committee established by the Board of Higher Education to determine Illinois medical education policies; and **Gerald Riordan, M.D.**, President of the Sangamon County Medical Society. **David L. Silber, M.D.**, Assistant Dean for Curriculum Affairs and Professor of Pediatrics was chosen by the graduates to hood the class.

NATIONAL SURVEY OF HEALTH MAINTENANCE ORGANIZATIONS now available. Conducted by the Twin City Health Care Development Project of Minneapolis, Minnesota, the study presents detailed information and statistics covering the more than 160 different HMO's now in operation throughout the country. Copies of this survey can be purchased from the Twin City Health Care Development Project, Federal Reserve Bank Building, Minneapolis, Minnesota 55480.

NEW HOSPITAL CME CONSULTATION SERVICE—Would an outside view improve your hospital CME? The Illinois Council on CME announces a new Consultation Service that can improve your in-hospital CME by helping you to build an up-to-date conception designed to enhance individual physicians' full clinical potential and discard stereotyped group efforts to "keep up."

The two-part process begins with self-analysis using a unique 16-page booklet—FREE to Illinois hospitals. The second part (if you desire it) provides a personal visit and report by an expert on effective in-hospital CME. For the consultant's visit, a modest charge is necessary to cover his honorarium, travel, and related costs.

The self-analysis form, basis for the consultation service, is the conception of Jacob R. Suker, M.D., Associate Dean for Graduate & Postgraduate Education, Northwestern University, as chairman of a committee including Robert T. Fox, M.D., and John Graettinger, M.D., of Rush Medical College. For full information, ask for the "Consultation booklet," or write or call: Illinois Council on CME, 55 E. Monroe St., Suite 3510, Chicago, 60603. Phone (312) 236-6110.

PHYSICIANS IN THE NEWS—William M. Lees, M.D., has been named Chief of Staff at the Veterans Administration Hospital, Hines, and Associate Dean for Veterans Affairs at the Loyola University Stritch School of Medicine, Maywood.

The First Annual Clarence W. Monroe Prize was awarded to **Karin Plym Forshell, M.D.,** of the University of Chicago, First Prize for a paper entitled "Microcirculatory Changes after Distant Burn Injury." Second place went to **Charles Nielsen, M.D.,** Northwestern University for "Mucormycosis of the Paranasal Sinuses" and third place to **J. Christopher Hastings, M.D.,** University of Illinois for "The Effect of Injury, Repair and Ascorbic Acid Deficiency upon Collagen Accumulation in Peripheral Nerves." The Clarence W. Monroe Prize for the best three papers presented at the Annual Residents' Evening was established last year in honor of Dr. Monroe by the Chicago Society of Plastic Surgery.

Newly elected officers of the Illinois Psychiatric Society are **Francois E. Alouf, M.D.,** President; **Alex J. Spadoni, M.D.,** President-Elect; **Clifton Rhead, M.D.,** Secretary; **Robert de Vito, M.D.,** Treasurer. Councilors for 1975-77 are **Nathaniel Apter, M.D.; Roy Grinker, Jr., M.D.;** and **David L. Rosenberg, M.D.**

The Illinois Association of Ophthalmology newly elected officers are **Robert S. Baller, M.D.,** President; **Warren W. Kreft, M.D.,** President-Elect; **Edward Kwedar, M.D.,** Vice-President; **Richard Meyer, M.D.,** Treasurer; and **Robert W. Ridley, M.D.,** Secretary.

Northwestern University Medical School has established the Otho S. A. Sprague Professorship of Medicine and named **David P. Earle, M.D.,** professor and former chairmen of the Department of Medicine, to this honor. Dr. Earle has coordinated a team investigation of kidney physiology and disease supported by Sprague gifts for more than a decade.

John M. Beal, M.D., Professor and Chairman of Surgery in the Northwestern University School of Medicine and editor of the Illinois Medical Journal "Surgical Grand Rounds," received a Distinguished Service Award from The University of Chicago Medical Alumni Association at the University's annual Medical Alumni Day, June 12. Dr. Beal also presented a lecture on "Bacteria and Biliary Tract Disease."

Former director of the Illinois Department of Public Health, **Franklin D. Yoder, M.D.,** who now resides in Greeley, Colorado, was elected President-Elect of the Colorado Public Health Association during its annual meeting in Colorado Springs.



President's Page

Long Range Planning

No desire for organized growth can be successful without ongoing self evaluation. Constant redetermination of basic beliefs and how they relate to present challenges is imperative for the strength of an organization. I have spoken to this point previously.

An inherent component of this premise is the presence of long range planning. Without this, an organization is a reactor rather than an initiator. Without this, one cannot move to prevent, but only to respond . . . and can only hope to achieve compromise at a level less than necessary.

Under the chairmanship of ISMS President-Elect Dr. Joseph Skom there is now a formal opportunity for the membership to be involved in long range planning. This committee, as organized by the House of Delegates at the request of ISMS Immediate Past-President Dr. Fredric Lake, has a unique opportunity to undertake the planning so vital to our society's future.

Membership communication to this committee is imperative. The concerns of the membership must be addressed and evaluated by this committee so that inclusion of meritorious concerns in this society's future plans may be accomplished.

I ask you to inundate Dr. Skom and this committee with your thoughts and ideas which relate to the direction and strength of this organization. Only with membership input, long range planning and strong leadership can we become more responsive, innovative and productive.

Send communications to: Dr. Joseph Skom, Chairman, ISMS Committee on Planning and Priorities, 55 E. Monroe, Suite 3510, Chicago, 60603.

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In **Gonorrhea,** the drug regimen of choice is aqueous procaine penicillin G. In uncomplicated cases, administration of 4.8 million units together with 1 gram oral probenecid, given at least 30 minutes prior to injection, is recommended.

Indications: In treatment of moderately severe infections due to penicillin G-sensitive microorganisms sensitive to the low and persistent serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

NOTE: When high sustained serum levels are required use aqueous penicillin G, IM or IV.

The following infection will usually respond to adequate dosages of intramuscular procaine penicillin G.—*N. gonorrhoeae:* acute and chronic (without bacteremia).

For deep intramuscular injection only.

Contraindication: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy.

Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen and intravenous corticosteroids should also be administered as indicated.

Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents e.g., pressor amines, antihistamines and corticosteroids.

Mental disturbances, including anxiety, confusion, agitation, depression, and hallucinations, have been reported in individuals following single-dose schedules for gonorrhea. Reactions have been transient, lasting from 15-30 minutes.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injections may produce neurovascular damage.

A small percentage of patients are sensitive to procaine. If there is a history of sensitivity, make the usual test: Inject intradermally 0.1 cc. of a 1 to 2 percent procaine solution. Development of an erythema, wheal, flare or eruption indicates procaine sensitivity. Sensitivity should be treated by the usual methods, including barbiturates, and procaine penicillin preparations should not be used. Antihistaminics appear beneficial in treatment of procaine reaction.

The use of antibiotics may result in overgrowth of nonsusceptible organisms. Constant observation of the patient is essential. If new infections due to bacteria or fungi appear during therapy, discontinue penicillin and take appropriate measures.

If allergic reaction occurs, withdraw penicillin unless, in the opinion of the physician, the condition being treated is life threatening and amenable only to penicillin therapy.

When treating gonococcal infections with suspected primary or secondary syphilis, perform proper diagnostic procedures, including darkfield examinations. In all cases in which concomitant syphilis is suspected, perform monthly serological tests for at least four months.

Adverse Reactions: (Penicillin has significant index of sensitization) skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported. (See "Warnings.")

As with other antisyphilitics, Jarisch-Herxheimer reaction has been reported.

Dosage and Administration : Administer only by *deep intramuscular injection,* in upper outer quadrant of buttock. In infants and small children, midlateral aspect of thigh may be preferable. When doses are repeated, vary injection site. Before injection, aspirate to be sure needle bevel is not in blood vessel. If blood appears, remove needle and inject in another site.

Although some isolates of *Neisseria gonorrhoeae* have decreased susceptibility to penicillin, this resistance is relative, not absolute, and penicillin in large doses remains the drug of choice. Physicians are cautioned not to use less than recommended doses.

Gonorrheal infections (uncomplicated)—Men or Women: 4.8 million units intramuscularly divided into at least two doses and injected at different sites at one visit, together with 1 gram of oral probenecid, preferably given at least 30 minutes prior to injection.

NOTE: Treatment of severe complications of gonorrhea should be individualized using large amounts of short-acting penicillin. Gonorrheal endocarditis should be treated intensively with aqueous penicillin G. Prophylactic or epidemiologic treatment for gonorrhea (male and female) is accomplished with same treatment schedules as for uncomplicated gonorrhea.

Retreatment: The National Center for Disease Control, Venereal Disease Branch, U.S. Dept. H.E.W. recommends:

Test cure procedures at approximately 7-14 days after therapy. In the male, a gram-stained smear is adequate if positive; otherwise, a culture specimen should be obtained from the anterior urethra. In the female, culture specimens should be obtained from both the endocervical and anal canal sites.

Retreatment in males is indicated if urethral discharge persists 3 or more days following initial therapy and smear or culture remains positive. Follow-up treatment consists of 4.8 million units aqueous procaine penicillin G, I.M. divided in 2 injection sites at single visit.

In uncomplicated gonorrhea in the female, retreatment is indicated if follow-up cervical or rectal cultures remain positive for *N. gonorrhoeae.* Follow-up treatment consists of 4.8 million units aqueous procaine penicillin G daily on 2 successive days.

Syphilis: all gonorrhea patients should have a serologic test for syphilis at the time of diagnosis. Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

Composition: Each disposable syringe 2,400,000 units (4-cc. size) contains procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer, and as w/v approximately 0.5% lecithin, 0.5% carboxymethylcellulose, 0.5% povidone, 0.1% methylparaben, and 0.01% propylparaben. The multiple-dose 10-cc. vial contains per cc. 300,000 units procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer and approximately 7 mg. lecithin, 2 mg. carboxymethylcellulose, 3 mg. povidone, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 1.2 mg. methylparaben, and 0.14 mg. propylparaben.

Five are graduating with honors. How many with VD?

On the average, you can figure the incidence of VD among teenagers at about 900 per 100,000 population* And growing.

Among those in the 20-24 age-group, the incidence is even higher. And it, too, is growing.

In the long run, a populace educated to the risks and prevention of VD is probably the best answer to the problem. Meanwhile, though, adequate doses of the recommended types of penicillin remain a formidable weapon.

IN SYPHILIS
INJECTION
Bicillin® L-A
(STERILE BENZATHINE PENICILLIN G SUSPENSION) WYETH

Syphilis is preferably treated with benzathine penicillin G, which is also the drug of choice for prophylaxis after exposure. Administration of 2.4 million units (1.2 million in each buttock) usually cures most cases of primary, secondary and latent syphilis with negative spinal fluid.

Indications: In treatment of infections due to penicillin G-sensitive microorganisms that are susceptible to the low and very prolonged serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

The following infections will usually respond to adequate dosage of intramuscular benzathine penicillin G.—Venereal infections: Syphilis, yaws, bejel and pinta.

For deep intramuscular injection only.

Contraindication: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported. Anaphylaxis is more frequent following parenteral therapy but has occurred with oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens.

Severe hypersensitivity reactions with cephalosporins have been well documented in patients with history of penicillin hypersensitivity. Before penicillin therapy, carefully inquire into previous hypersensitivity to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and treat with usual agents, e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injection may produce neurovascular damage.

In streptococcal infections, therapy must be sufficient to eliminate the organism; otherwise the sequelae of streptococcal disease may occur. Take cultures following completion of treatment to determine whether streptococci have been eradicated.

Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms including fungi. Take appropriate measures should superinfection occur.

Adverse Reactions: Hypersensitivity reactions reported are skin eruptions (maculopapular to exfoliative dermatitis), urticaria and other serum sickness-like reactions, laryngeal edema and anaphylaxis. Fever and eosinophilia may frequently be only reaction observed. Hemolytic anemia, leucopenia, thrombocytopenia, neuropathy and nephropathy are infrequent and usually associated with high doses of parenteral penicillin.

As with other antisyphilitics, Jarisch-Herxheimer reaction has been reported.

Dosage and Administration: Venereal infections—

Syphilis—Primary, secondary and latent—2.4 million units (1 dose).

Late (tertiary and neurosyphilis)—2.4 million units at 7 day intervals for three doses.

Congenital—under 2 years of age, 50,000 units/Kg. body weight; ages 2-12 years, adjust dosage based on adult dosage schedule.

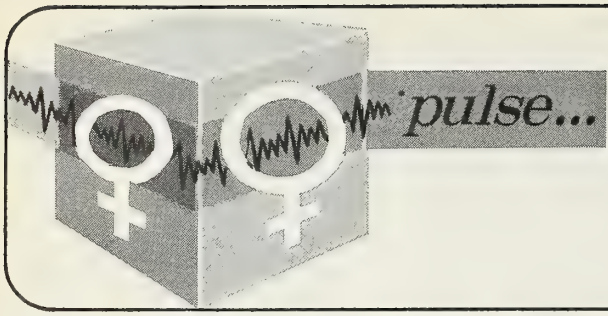
(Shake multiple-dose vial vigorously before withdrawing the desired dose.) Administer by **deep intramuscular injection** in the upper outer quadrant of the buttock. In infants and small children, the midlateral aspect of the thigh may be preferable. When doses are repeated, vary the injection site. Before injecting the dose, aspirate to be sure needle bevel is not in a blood vessel. If blood appears, remove the needle and inject in another site.

Composition: Units benzathine penicillin G (as active ingredient): 2,400,000 units in 4-cc. single dose disposable syringe. Each disposable syringe also contains in aqueous suspension with sodium citrate buffer, as w/v approximately 0.5% lecithin, 0.6% carboxymethylcellulose, 0.6% povidone, 0.1% methylparaben, and 0.01% propylparaben. 300,000 units per cc.—10-cc. multi-dose vial. Each cc. also contains sodium citrate buffer, approximately 6 mg. lecithin, 3 mg. povidone, 1 mg. carboxymethylcellulose, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 1.2 mg. methylparaben, and 0.14 mg. propylparaben.

Wyeth Laboratories
Philadelphia, Pa. 19101



*U.S. Dept. of Health, Education, and Welfare: VD Fact Sheet 1972 Publication No (HSM) 73-8195



pulse... of the doctor's wife

Mrs. Harold Keegan, Editor

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Atlantic City 1975

The Annual meeting of the AMA Auxiliary was held in Atlantic City, N.J., June 15-18, 1975.

Mrs. Howard Liljestrand, President, presided at the meeting. Illinois received several awards for our contributions to AMPAC and also received recognition for increased membership.

Mrs. Erle E. Wilkinson of Tennessee was installed as the new President at the close of the meeting.



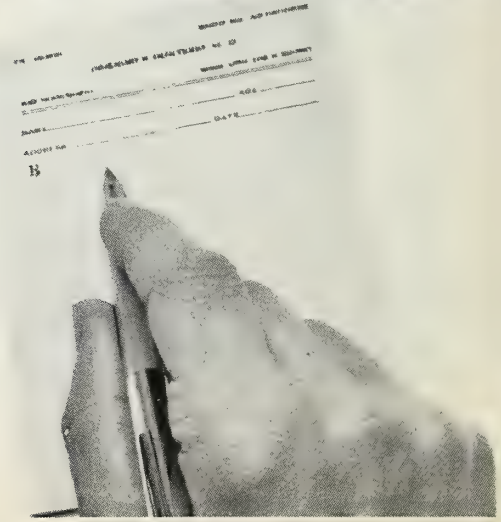
Mrs. Thomas Glatter, Immediate Past President of ISMS Auxiliary, holds AMA-ERF Award.



Delegates at AMA Auxiliary Convention. First row: (left to right) Mrs. Wendell Roller, Mrs. John Ovitz, Jr., President-Elect, ISMS Auxiliary, Mrs. Eugene Vickery, President, ISMS Auxiliary, Mrs. Edward Szewczyk, and Mrs. Thomas Glatter, Immediate Past President, ISMS Auxiliary. Second row: (left to right) Mrs. Walter G. Bornemeier, Mrs. Glen Marshall, Mrs. August Martinucci, Mrs. Frank Torrey, Mrs. Harold R. Keegan, Mrs. Frank Holman, and Mrs. Bruno Beinoris.



Bioequivalence



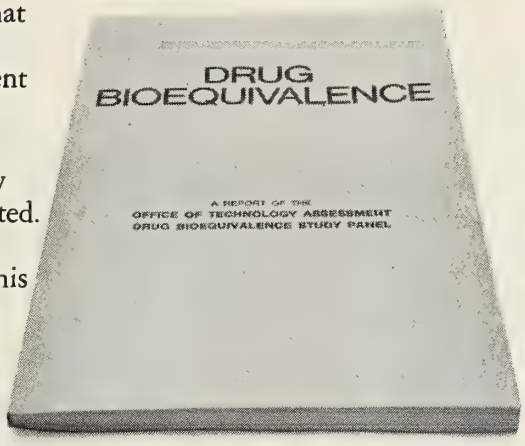
the weight of scientific opinion:

If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivalency in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.



"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and (b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or (c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

protecting the integrity of your prescription



The "Housestaff News" is designed for interns and residents. News items and short articles of interest to housestaff will be considered for publication; materials should be sent to Michael Hughey, M.D., 711 Laurel Avenue, Wilmette, Ill. 60091.

Housestaff Physicians and the IRS

Under section 117 of the Internal Revenue Service Code, individuals who are not working for a degree, but who are awarded fellowship or scholarship grants may exclude up to $300 per month for 36 months from their income as tax-free income. This section of the code has a peculiar relevence to interns and residents since they are often being paid both for their services as well as to further their eduaction. Because of the rather fine line between salary and stipend in the case of post-graduate medical education, there has been considerable controversy in the past as to whether residents should indeed qualify for this income exclusion.

Neither auditors nor tax courts have been consistent in their dealing with the Section 117 exclusion. In several cases, residents claiming the exclusion who have been audited have had the exclusion accepted by the auditor. Others have had the exclusion denied, only to have it accepted by the district conferee (the first step in the appeals process). Of those cases which have reached the District Tax Court, many residents claims for the exclusion have been supported.

Unfortunately, not all tax courts have agreed to allow residents to exclude this part of their income. The most recent widely-published case occurred in Milwaukee, where several general surgery residents lost their bid to qualify for the exclusion (*Rosenthal v. Commissioner of Internal Revenue,* United States Tax Court, January 13, 1975). A brief summary of the case may be found in *Resident and Staff Physician,* May, 1975, Page 128.

Because of the uncertainty of whether any individual resident will qualify for the exclusion, it has been advised that the resident should claim the exclusion, but put the money in a bank to collect interest, and *not* spend it until the three year statute of limitations has expired for that tax year. In addition, any resident claiming the exclusion should carefully examine whether he indeed qualifiies for the exclusion, and be prepared to document the qualification.

Funding Approved for Resident Advisory Committee

The ISMS House of Delegates again has approved a $1.00 special assessment to each member of the Illinois State Medical Society this year to support the activities of the Advisory Committee to Physicians-in-training, and the Advisory Committee to Medical Students. With this funding, the committee can continue its activities of membership recruitment, liaison between housestaff and the Illinois State Medical Society, and examination of specific items of interest to housestaff physicians in the state.

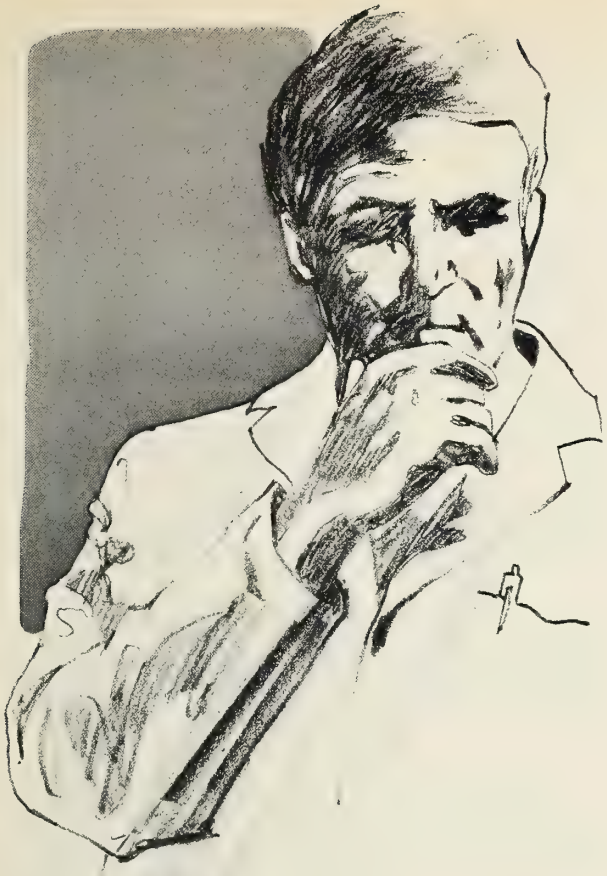
In its expanding role, the committee will serve as an essential link in communication between different housestaff organizations and may assume a counseling role in housestaff grievances. Housestaff appointments to the committee for this year include:

Edith Hartman, M.D. (Illinois State Pyschiatric Institute)
Michael Hughey, M.D. (Evanston Hospital)
Gaylord Nordine, M.D. (Northwestern University)
K. Thomas Papreck, M.D. (St. Johns Hospital, Springfield)
Gerald Snyder, M.D. (Methodist Hospital, Peoria)
Paul Stromborg, M.D. (Cook County Hospital)

New Contracts for Housestaff

Across the state, many housestaff organizations have been negotiating new contracts for 1975-1976. In some cases, the AMA's "Guidelines for Housestaff Contracts or Agreements" have been used as ground work for the new contracts. Increases in yearly stipends have been noted, frequently ranging from 5 to 10% over last year's stipends. Most first-year residents in the Chicago area are to receive stipends amounting to $12,000 to $14,000 for next year.

Moonlighting clauses in the contracts continue to be a hotly debated item. Many of the contracts now stipulate that outside remunerative medical activities must be disclosed if requested, and that they must be ceased if found to be detrimental to the resident's in-hospital performance. Copies of the AMA "Guidelines" are available without charge from the AMA.



DOCTOR is your Medical Assistant keeping in step with you?

KEEPING IN STEP

To be an effective member of the health care team, a proficient medical assistant must keep up to date and in tune with the changing times. Her knowledge of new procedures and advances in medicine should keep pace with yours.

American Association of Medical Assistants (AAMA) is the only medical assistants' organization to have merited official commendation by the American Medical Association.

MEMBERSHIP

AAMA is a professional association for medical assistants, secretaries, nurses, technicians, bookkeepers or receptionists in a doctor's office or other medical facility.

BENEFITS

Membership in AAMA opens the door to professional growth. The association offers medical assistants:

- **Continuing education**
- **Study programs**
- **Opportunity for Certification**
- **Bi-monthly journal**
- **Loan and scholarship programs**
- **Professional prestige**
- **Group insurance**
- **Fellowship**
- **Direction to good public relations**

NON-PROFIT, NON-UNION

AAMA is a non-profit organization. It is not nor shall it ever become a trade union or collective bargaining agency.

PHYSICIAN-ADVISORY COMMITTEE

Qualified physicians are elected as advisors at local, state and national levels. They counsel with officers and committee chairmen throughout the year.

HELP HER JOIN

Enroll your medical assistant today. Her improved job performance will assure both of you a good return on the investment in dues.

Call or write for further information:
Mrs. Magda Brown, President
Illinois Society, American
Association of Medical Assistants
4250 Main Street
Skokie, Illinois 60076
312/677-9016

American Association of Medical Assistants, Inc.
(Executive Office)
One East Wacker Drive, Suite 1510
Chicago, Illinois 60601

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

ALBANY: Small town on bank of Mississippi river needs general practitioner. Ideal modern brick building with parking area available. Two recently new, well equipped hospitals at Clinton—8 miles away. Nice community, two factories nearby. Contact: Mrs. Warden Welch, Park Street, Box 441, Albany 61230 (309-887-4461) (10)

BELLEVILLE: Pulmonary Disease Specialist—Part Time Director wanted for modern 329 bed full service community hospital with extensive building program. Complete specialty backup. 500,000 served by local hospitals. No pulmonary specialist in hospital or private practice. Contact: Matthew Eisele, M.D., Memorial Hosital, 4501 North Park Drive, Belleville, 62223. (618) 233-7750, Ext. 345 (11)

BELLEVILLE: Emergency Medical Services Director wanted for modern 329 bed full service community hospital. Areawide Trauma Center. Emergency Department expanding to 10,900 square feet. Full time physician coverage since January, 1971. Complete specialty backup. Financial arrangements negotiable. Contact: Matthew Eisele, M.D., Memorial Hospital, 4501 North Park Drive, Belleville, 62223. (618) 233-7750, Ext. 345. (11)

BLOOMINGTON — General Practitioners urgently needed. Guaranteed salary with percentage of the business done. Excellent opportunity for energetic young physicians. For further information contact—P. G. Theobald, M.D., President, Theobald Medical Center, #1 Medical Hills Drive, Bloomington, 61701. (9)

BOLINGBROOK—28,000 population, fast growing. Fastest growing community in the state. Short on Professional services, particularly physicians and dentists. 30 miles from Chiago Loop, conveniently located at the intersection of I-55 and Rt. 53. Openings for Family Medicine, Internist, Surgeon, OB-GYN in new Professional Building. Occupancy April-May 1975. Contact: James Pontoriero, M.D., (312) 739-5121. (9)

BROOKFIELD: Going practice - population 24,000. 17 miles southwest of Chicago. Complete office facilities. Considering retirement. Contact: Dr. C. F. Hubner, 8922 Fairview Ave., Brookfield, 60513, (312) 485-6660. (8)

CARBONDALE: A Board Certified or Eligible Radiologist is wanted to join a Board Certified Radiologist in a 30 man multi-specialty clinic in Southern Illinois. A large university and new medical school are located in the community. Excellent starting salary, teaching opportunities and fringe benefits. Contact: Wayne Given, Carbondale Clinic, PO Box 2347, Carbondale 62901. (10)

CARMI: Unusually attractive opportunity. Join three Family Physicians in southern Illinois community with drawing population of 18,000. Office adjacent to fully accredited Family Physician Hospital. Guaranteed income of $36,000 first year. Early partnership. Must investigate to appreciate. Call collect days: 618-382-8303; evenings: 618-382-4008. (8)

CARROLLTON: Ample excellent opportunities in Greene County for Family physician. Group practice being set up in new office accommodating 4-5 M.D.'s next to hospital. For further information contact: Dr. Caselton, or Dr. Chung or Roy Shoemaker, 800 School Street, Carrollton 62016 (217-942-6946) (9)

CHADWICK: Town needs DOCTOR—have been without Doctor since former retired. Complete office building—available for immediate use. Location in center of rich farming community—good recreational facilities nearby. A very good place to live. Contact: Frank W. Mest, POB 148, Chadwick 61014 (815-684-5173) (10)

CHICAGO: Established Medical Center, near west side, needs Family Practitioner, patient load 20-30 daily. Lab and EKG on hand. X-ray facilities available. Podiatrist, Optometrist and Pharmacy present. Must have Illinois license and insurance. Contact: Mr. Thomas Gajewicz, Jane Addams Medical Center, 1345 W. Taylor Street, Chicago, 60646 (312-942-0476). (8)

CHICAGO: If you are interested in a 37½ hour week with **no** night calls and salary commensurate, private practice, counting expenses, and willing to enjoy a national reputation in approximately 2 years, call or write Charles Hild, Professional Recruiter, State of Illinois, 160 North LaSalle, Chicago, 60601, 312-793-3866. (8)

GALENA: Pop. 4,500. Family/General Practitioner wanted to join three other FPs in county seat town. Complete office facilities adjacent to new 32-bed hospital and 34-bed skilled nursing care facility. Fifteen miles from city of 65,000. This historically rich community nestled in the Galena river valley and hillside offers a very good school system, numerous churches, outstanding recreational facilities (golf courses, ski lodge, swimming pool, tennis courts, fishing, boating and water skiing). Contact Dr. W. E. Johnson, 300 Summit St., Galena, 61036 - Tel. (815) 777-0900. (9)

LITCHFIELD: GP's & Peds. Located on I 55 midway between Springfield & St. Louis. Office space available in new medical arts building. Guaranteed income and other financial assistance available. New 140 bed hospital with full time ER coverage by trauma center physicians. Practice opportunities unlimited. Contact: Lee Johnson, M.D., St. Francis Hospital (217-324-2191) or John Short, 723 N. Van Buren, Litchfield 62056 (217-324-3937). (10)

ROUND LAKE: Family Practioner need in a growth community. Complete office facility available, due to recent death of GP. Family and Industrial practice—drawing population 25,000. Location North Eastern area, centered between Chicago and Milwaukee. Three hospital affiliation—fully accredited—total 954 beds. Excellent opportunity. All recreational facilities nearby. Contact: Doris Brundza, POB 488, Round Lake 60073, 312-546-4623 (11)

MURPHYSBORO: Population 10,000. Wanted FP and OB-GYN to associate with 3-man group: 1 surgeon, 1 FP, 1 internist. Six miles from S.I.U. Good schools. Beautiful lakes for recreation. Good fringe benefits. Contact Medical Arts Clinic, Ltd., W. J. Borgsmiller, President. 215 N. 14th, Murphysboro, 62966. (618) 684-2172. (9)

ROCKFORD: Orthopedic Surgeon, General Internist, Cert/Elig. to associate with a 25 man multi-specialty clinic in a city of 150,000 population serving an area of 300,000 people; minimum salary guarantee with no upper limits; retirement plan and fringe benefits; teaching available through local Medical School—a branch of Univ. Ill. Contact: N. R. Dougherty, M.D., Canfield Clinic, LTD., 1215 N. Alpine Rd., Rockford 61107, (815-397-0180) (10)

SAVANNA: Population 5,000. Service area 20,000. Modern 38 bed acute care facility; developing family practice group. Have openings for three family practitioners or internists. Will provide office space and financial assistance. Located in beautiful recreational area on Mississippi River. Excellent school system. Contact: M. J. Stretton, Savanna City Hospital, Savanna 61074 (815-273-7751) (10)

VANDALIA: Population 6,000. Family physicians needed. Office space available. Hospital with 100 beds, all services. An excellent school system and all denominations of churches. One hour from St. Louis on the interstate highway. Local lake for boating and fishing, close to the Carlyle Lake. Recreational facilities. Contact: D. H. Rames, M.D., 1029 N. 8th St., Vandalia, 62471 (618-283-3012) or Larry Harrison, Administrator, Fayette County Hospital, Vandalia, 62471 (618-283-1231). (12)

WAUKEGAN: North Chicago. Population 100,000 - 40 miles north of Chicago. Primary care physician needed to head existing medical and dental clinic with a growing patient load. Clinic to work in cooperation with medical school and local hospital to train primary care physicians. Salary open. Contact Mrs. Lopez — Waukegan-North Chicago Partnership for Health Clinic, 701 Tenth Street, North Chicago, 60064, 312-473-2744. (10)

WHITE HALL: Population 3,000. Location midway between St. Louis, Mo. and Springfield, Ill. One physician at present. 30-bed hospital, new nursing home, 80 bed, construction underway increasing to 140 beds. Office facility available. Recreational facilities nearby. Contact: George Stahl, 407 N. Main St. White Hall, 62092, 217-374-2121. (8)

Viewbox

(Continued from page 47)

DIAGNOSIS: *Giant hydronephrosis of the kidney*—Intravenous pyelogram, Figure 1, reveals faint outlines of a markedly dilated collecting system consistent with a hydronephrosis. Abdominal aortogram (Figure 2) reveals a markedly atretic renal artery on the left with displacement of abdominal aorta to the right. The renal artery branches are splayed around large hydronephrotic sacs. Figure 3 reveals a left retrograde examination in which the distal half of the ureter is outlined and is displaced over to the right by the giant sized left kidney and accounts for the slight compression of the right ureter seen on the intravenous pyelogram. At surgery a giant hydronephrotic sac was identified with practically no blood supply present.

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ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110

Items for this Calendar must be received 90 days prior to the even Those received earlier may appear in up to three monthly issues.

WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

August, 1975

Family Medicine

SPECIALTY REVIEW COURSE FOR FAMILY PRACTICE
For: MDs. 10 ½ day-course, August 18-29, Chgo. **CME Credit:** 98 hrs., AMA Cat. 1. **Fee:** $325. Cook County Grad. Schl./Med., 707 S. Wood St., Chgo. 60612.

September, 1975

Anesthesiology

SCIENTIFIC FOUNDATIONS FOR CLINICAL PRACTICE
For: GPs, FPs, Nurse Anesthetists. Sept. 26-28. **Symposium, Speaker:** Mark Ravin, M.D., Univ. of Kentucky College of Med., Lexington, Ky. **CME Credit:** 7 hrs. AMA Cat. 1. AAFP Prescribed. Amer. Assoc. of Nurse Anesthetists: 8.5 points. **Fee:** $45. **Reg. Limit:** 90. **Sponsor, contact:** Dept. of Anesthesiology, Office of C.E., Univ. of Ky. Coll. of Med. and Office of C.E., College of Nursing, Univ. of Ky. Lexington, Ky. 40506.

Basic Science

STATE & NATIONAL BOARD REVIEW COURSE, BASIC
For: GPs. 6½ day-Course. Sept. 28-Oct. 4, Chgo. **CME Credit:** 58 hrs. AMA Cat. 1. **Fee:** $225. **Reg. Limit:** 105. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

Cancer

THIRD ANNUAL CHICAGO SYMPOSIUM—NEOPLASM IMMUNITY: MECHANISMS
For: Oncologists, Surgeons, Internists, Hematologists. Two-day conference, Sept. 11-12, Blackstone Hotel, Chicago. **Credit:** 10 hrs. AMA Category 2. **Sponsor, contact:** Ray G. Crispen, M.D., Institute/TB Research, U/Illinois, 904 W. Adams, Chicago 60607.

Cardiovascular Disease

SPECIALTY REVIEW COURSE IN CARDIOVASCULAR DISEASE
For: Board certified or eligible applicants. 5-day Course. Sept. 22-26. Chgo. **CME Credit:** 40 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

Endocrinology

SPECIALTY REVIEW COURSE IN ENDOCRINOLOGY
For: Board certified or eligible applicants. 5-day Course. Sept. 8-12. Chgo. **CME Credit:** 40 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

Diabetes Mellitus

SECOND SYMPOSIUM ON DIABETES MELLITUS
For: Allied health professionals. **Symposium and Workshop.** Sept. 9 and 10. Playboy Towers Hotel, Chicago. **Fee:** $25 - 2 days; $15 - 1 day. **Reg. Deadline:** Sept. 5. **Sponsor, contact:** American Diabetes Assoc., 620 North Michigan Ave., Chicago, Ill. 60611, Nike Bradley, Ex. Dir.

Gastroenterology

SPECIALTY REVIEW COURSE IN GASTROENTEROLOGY
For: Board certified or eligible applicants. 5-day Course. Sept. 22-26. Chgo. **CME Credit:** 40 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

General Medicine

FLUIDS AND ELECTROLYTE MANAGEMENT
For: GP, IM, FP, Surg. 5-day Course. Sept. 22-26. Chgo. **CME Credit:** 35 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 50. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

Medicine

UPDATE ON ANTIBIOTICS
For: All physicians, nurses, paramedics. Seminar, Sept. 23. Speaker, Walter S. Wood, M.D. **Credit:** 1 hr. AMA Category 1. **Sponsor, contact:** John Huss, M.D., Memorial Hospital/DuPage County, Avon & Schiller, Elmhurst 60126.

DERMATOLOGY IN FAMILY PRACTICE
For: All physicians. Visiting Lecturer: A. Schroeter, M.D., Mayo Clinic. Sept. 19: 10 AM, Grand rounds, Forkosh Hosp.; 6:00 PM, lecture, Lincolnwood Hyatt House. Sept. 20: 10 AM Grand rounds, Bethany Methodist Hosp. **Credit:** 5 hrs. AMA Category 1. **Fee,** deadline (for dinner only): $10, Sept. 15. **Sponsor, contact:** Shephard Plotner, FAB^3-CME, Forkosh Hosp., 2544 W. Montrose, Chicago 60618; (312) 267-2200.

Medical Oncology

SPECIALTY REVIEW COURSE IN MEDICAL ONCOLOGY
For: Board certified or eligible applicants. 5-day Course. Sept. 8-12. Chgo. **CME Credit:** 40 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

Neurology, Psychiatry

NEUROLOGY, PART II, CLINICAL
For: All physicians. 5½ day Course. Sept. 8-13. Chgo. **CME Credit:** 44 hrs. AMA Cat. 1. **Fee:** $225. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

Obstetrics & Gynecology

GYNECOLOGICAL LAPAROSCOPY
For: OB/GYN. 3-day Course. Sept. 10-12. Chgo. **CME Credit:** 18 hrs. AMA Cat. 1. **Fee:** $250. **Reg. Limit:** 8. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

Opthalmology

THE EYE IN SYSTEMIC DISEASE
For: Physicians, nurses. Lecture, Sept. 24, 1975. **Speaker:** Howard Reinglass, M.D. **Credit:** 1 hr. AMA Category 1; 2 hrs. AAFP elective. **Sponsor, contact:** Fernando Lopez-Fernandez, M.D., Martha Washington Hospital, 4055 N. Western, Chicago 60618.

Orthopaedics

SPECIALTY REVIEW COURSE IN ORTHOPAEDICS
For: Board certified or eligible applicants. 7-day Course. Sept. 7-13. Chgo. **CME Credit:** 64 hrs. AMA Cat. 1. **Fee:** $225. **Reg. Limtt:** 350. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

Psychiatry

LECTURE SERIES: "PAIN AND ANGST AND THEIR ALLEVIATION"
For: Physicians and Mental Health Professionals. **Series:** Sept. '75-April '76. Sept. 17, 7:30-9:30 PM. "Rolfing." **Speaker:** Ida Rolf, Ph.D. Forest Hospital, Des Plaines, Ill. **Fee:** $90 (entire series), $15 (ind. lecture). **CME Credit:** 2 hrs. AMA Cat. 2. AAFP Elective. **Co-Sponsors:** Forest Hospital Foundation and Chicago Medical School. **Contact:** Forest Hospital, 555 Wilson Lane, Des Plaines, IL 60016. Att'n: June Bengsten.

Surgery

MANAGEMENT OF COMPLICATIONS IN SURGERY
For: All physicians. 4-day Course. Sept. 29-Oct. 2. Chgo. **CME Credit:** 28 hrs. AMA Cat. 1. **Fee:** $175. **Reg. Limit:** 55. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

Urology

REVIEW COURSE IN SEXUAL DYSFUNCTION AND RELATED TOPICS
For: All physicians. 2-day Course. Sept. 29-30. Chgo. **CME Credit:** 12 hrs. AMA Cat. 1. **Fee:** $80. **Reg. Limit:** 60. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

Recent CME Accreditations

The ISMS Committee on CME Accreditation has recently approved the CME programs of these institutions:

Chicago Lakeshore Hospital
Chicago

St. Anthony Hospital
Rockford

St. Joseph Hospital
Elgin

Oak Forest Hospital
Oak Forest

October, 1975

Anesthesia

REGIONAL ANESTHESIA & THERAPEUTIC NERVE BLOCKING
For: All physicians. 5-day Course. Oct. 6-10. Chgo. **CME Credit:** 40 hrs. AMA Cat. 1. **Fee:** $300. **Reg. Limit:** 8. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

ELECTROCARDIOGRAPHY FOR ANESTHESIOLOGISTS
For: All physicians. 5-day Course. Oct. 27-31. Chgo. **CME Credit:** 35 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 35. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

Cardiology

TREATMENT OF ARRHYTHMIAS
For: Physicians, nurses, students, paramedics. **Seminar. Speaker:** Dr. William B. Dwyer. Oct. 14. Memorial Hospital of DuPage County, Elmhurst, IL. **CME Credit:** 1 hr. AMA Cat. 1. **Fee:** none. **Sponsor:** Memorial Hospital of DuPage County, Avon & Schiller Sts., Elmhurst, IL. **Contact:** John H. Huss, MD.

Dermatology

ONE WEEK COURSE IN BASIC DERMATOLOGY
For: All physicians. 5-day Course. Oct. 13-17. **CME Credit:** 30 hrs. AMA Cat. 1. **Fee:** $175 **Reg Limit:** 30. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

Emergency Medicine

1975 ACEP/EDNA SCIENTIFIC ASSEMBLY
For: Emergency physicians, nurses, EMTS. Scientific Assembly with Postgraduate Courses. **Oct.** 7-9, 8 AM-7 PM. Las Vegas Convention Center, Las Vegas, NV. **CME Credit:** undetermined. **Fee:** not yet determined.**Sponsors:** Amer. Coll. of Emergency Physicians and Emergency Dept. Nurses Ass'n. **Contact:** Vincent J. Gebes, Am. Coll. of Emergency Physicians, 241 East Saginaw St., East Lansing, MI 48823.

Family Medicine

BASIC DERMATOLOGY
For: All physicians. 5-day Course. Oct. 13-17. Chgo. **CME Credit:** 30 hrs. AMA Cat. 1. **Fee:** $175. **Reg. Limit:** 30. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

WEBER MEDICAL CLINIC FALL SEMINAR
For: GPs. Oct. 25, 1-5 PM. **Speaker:** Richard Lynch, MD, Chief of Cardiology, SIU School of Medicine. Olney Central College Auditorium, Olney, IL. **CME Credit:** 4 hrs. AMA Cat. 1. **Fee:** none. **Reg. Limit:** 75. **Sponsor, contact:** Weber Medical Clinic and SIU School of Medicine, 1200 N. East St., Olney, IL 62450.

BASIC ELECTROCARDIOGRAPHY
For: All physicians. 5-day Course. Oct. 27-31. Chgo. **CME Credit:** 35 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 35. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

General Medicine

STATE AND NATIONAL BOARD REVIEW, COURSE, CLINICAL
For: All physicians. 6-day Course. Oct. 6-11. Chgo. **CME Credit:** 53 hrs. AMA Cat. 1. **Fee:** $225. **Reg. Limit:** 105. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

GENERAL MEDICINE LECTURE SERIES
For: Attending and House Staff. Oct. 7, 1975-June 25, 1976, 11 AM-12.30 PM. St. Mary of Nazareth Hosp. Center, Chgo. **Speaker:** Anthony Sapienza, MD. **CME Credit:** 1½ hrs. AMA Cat. 1. AAFP Elective. **Fee:** none. **Reg. Limit:** 50. **Sponsor:** St. Mary of Nazareth Hosp. Center, 2233 W. Division St., Chgo 60622. **Contact:** Anthony R. Sapienza, MD.

SEXUALITY FOR PHYSICIANS
For. All physicians. 5-day Course. Oct. 20-24. Chgo. **CME Credit:** 36 hrs. AMA Cat. 1. **Fee:** $225. **Reg Limit:** 100. **Sponsor, contact:** Cook County Grad School of Medicine, 707 S. Wood St., Chgo. 60612.

Internal Medicine

ADVANCED ELECTROCARDIOGRAPHY
For: Internists. 2½ day Course. Oct. 1-3. Chgo. **CME Credit:** 17 hrs. AMA Cat. 1. **Fee:** $125. **Reg. Limit:** 75. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

UPPER GASTROINTESTINAL ENDOSCOPY
For: Internists. 5½ day course. Oct. 10-15. Chgo. **CME Credit:** 33 hrs. AMA Cat. 1. **Fee:** $350. **Reg. Limit:** 8. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

Obstetrics & Gynecology

SPECIAL COURSE IN GYNECOLOGIC PATHOLOGY
For: OB/GYN. 5-day Course Oct. 6-10. Chgo. **CME Credit:** 35 hrs. AMA Cat. 1. **Fee:** $300. **Reg Limit:** 25. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

NUTRITION AND HUMAN REPRODUCTION: BIOCHEMICAL AND CLINICAL ASPECTS
For: Clinicians and researchers. **Symposium.** October 9 and 10. 8:30 AM-5 PM. Wayne State Univ., Detroit, MI. **Fee:** $85. **Reg. Deadline:** Sept. 15. **Limit:** 250. **Sponsor, contact:** Kamran S. Moghissi, MD, Dept. of GYN/OB, Wayne State Univ., 275 E. Hancock, Detroit, MI 48201.

SPECIALTY REVIEW COURSE IN OBSTETRICS & GYNECOLOGY
For: OB/GYN. 10½ day Course. Oct. 20-31. Chgo. **CME Credit:** 86 hrs. AMA Cat. 1. **Fee:** $375. **Reg. Limit:** 85. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

Pathology

SPECIAL COURSE IN GYNECOLOGIC PATHOLOGY
For: Pathologists. 5-day Course. Oct. 6-10. Chgo. **CME Credit:** 35 hrs. AMA Cat. 1. **Fee:** $300. **Reg. Limit:** 25. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

Psychiatry

LECTURE SERIES: "PAIN AND ANGST AND THEIR ALLEVIATION"
For: Physicians and Mental Health Professionals. **Series:** Sept. '75-April '76. Oct. 1, 7:30-9:30 PM. "Primal Therapy." **Speaker:** Michael Holden, M.D. Forest Hospital, Des Plaines, IL. **Fee:** $90 (entire series), $15 (ind. lecture). **CME Credit:** 2 hrs. AMA Cat. 2. AAFP Elective. **Co-Sponsors:** Forest Hospital Foundation and Chicago Medical School. **Contact:** Forest Hospital, 555 Wilson Lane, Des Plaines, IL. 60016.

Trauma

MANAGEMENT OF COMMON FRACTURES AND DISLOCATIONS
For: All physicians. 5-day Course. Oct. 27-31. Chgo. **CME Credit:** 35 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 30. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

★

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CLASSIFIED ADVERTISING

Positions & Practice Opportunities

OB-GYN and UROLOGY specialties to join an established successful practice with 16-man multi-specialty group. Excellent group benefits; retirement plan; modern clinic facilities; progressive community with excellent educational system including two colleges; area population 75,000; great recreational facilities; must be board eligible or certified; Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

PHYSICIANS WANTED—Family Practitioners; Pediatrician; Orthopedic Surgeons; E.N.T.; Dermatologist. Board eligible or certified. Pleasant community w/good schools, recreation, modern accredited hospital w/adjacent office space. Solo practice, low-pressure life style, small town living w/large metropolitan area only short distance. Box Number 849, Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603.

BOLINGBROOK-ROMEOVILLE-WOODRIDGE. Total poulation 70,000. Only six Doctors and four Dentists covering this area. Urgent need for additional help. For Association or solo contact: Bolingbrook Professional Building, 519 E. Briarcliff Rd, Bolingbrook, Illinois. 60439 (312-739-5121).

PEDIATRICIANS Two or three member group, beautiful office arrangement available, excellent immediate potential, midwest suburban location. Reply Box 853, c/o Illinois Medical Journal 55 E. Monroe, Chgo, Ill. 60603.

INTERNIST, PSYCHIATRIST, PRIMARY CARE PHYSICIAN. Internist to have clinical, consultative, and supervisory duties as Chief of Clinical Medicine; Psychiatrist to have clinical, consultative, and administrative duties as Head of Mental Health Unit. Progressive modern health service at large state university with enrollment of 20,000. Competitive salaries based on training and experience, good fringe benefits, ideal working conditions. Specialists must have completed residency; Illinois license required. Affirmative Action/Equal Opportunity Employer. Write L. W. Akers, Director, N.I.U., DeKalb, Illinois 60115.

CARDIOLOGISTS wanted on a part-time basis for the interpretation and serial comparison of ECGs. Experience with interpretation of Holter recordings is also desirable. Please apply in writing to: Dr. Louis C. Lax, c/o TELEMED Corporation, 2345 Pembroke Ave., Hoffman Estates, Illinois, 60172; or phone (312) 884-0900.

ILLINOIS: Immediate openings for full time physicians to augment present Emergency Service Department. Should be experienced in acute care but also sensitive to the needs of all primary care patients. Illinois license required. Hospital is a designated Trauma Center located 50 miles Northwest of Chicago. The community offers modern schools, shopping facilities, and recreational areas. Flexible work schedules, competitive salaries, and malpractice insurance coverage. Send resume to: Anthony Corcoran, Executive Director, McHenry Hospital, 3516 W. Waukegan Road, McHenry, Illinois 60050.

WANTED—CHIEF MEDICAL OFFICER to activate and direct a modern VA Ambulatory Care Clinic in Evansville, Indiana. Clinic will utilize many of the newest concepts in health care delivery and is scheduled to open soon. Beginning salary up to $36,000 depending on qualifications. 30 days vacation, 15 days sick leave, educational opportunities and many benefits. Licensed in any state. An Equal Employment Opportunity employer. Contact Chief of Staff, VA Hospital, Marion, IL 62959 Tel. 618-993-2151.

INTERNIST AND PEDIATRICIAN—Immediate opening—5-man multispecialty group needs third internist and second pediatrician. Group includes Gen. Surgeon and OB-Gynecologist, all Board Certified. Located next door to Community Hospital with recently completed additional primary care facilities. Community close to Metro-Milwaukee and two hours from Metro-Chicago. First year salary open. Excellent fringes including approved profit-sharing plan. Contact J. L. Algiers, M.D. (Int.) or P. M. Donahue, M.D., (Ped.) or Clinic Manager at Parkview Medical Associates, Ltd., 1004 East Sumner St., Hartford, WI 53027 or collect 414-673-5745.

Overhead consuming your profit? Tired of filling out insurance forms? Working long hours? Consider practicing at Illinois State University Health Service. 40 hour week — no nite call. You get paid health insurance, life insurance and retirement benefits, liberal vacation, etc. Equal opportunity employer. Illinois license. Visits invited. Call or contact: M. M. Torrey, M.D. Illinois State University, Bloomington/Normal, Illinois 61761. Phone (309) 438-8655.

GENERAL PRACTITIONER, RADIOLOGIST, INTERNIST OR GENERAL SURGEON. VA Hospital with active teaching and residency program. Salary based on qualifications according to VA salary scale. 40-hour basic work week. Liberal fringe benefits. Non-discrimination in employment. Write or call Chief of Staff, VA Center, Jackson, MS 39216, 601-362-4471.

ILLINOIS, CHICAGO—Emergency Physician, full time, for active department in urban university affiliated community hospital. Chicago "New Town" area near lake. Opportunity to participate in teaching program. Excellent income and benefits, near by apartments available. Experience or E. M. residency required. Send resume to Vera Morkovin, M.D.—Illinois Masonic Medical Center, 836 W. Wellington, Chicago, Illinois 60657, Tel. (312) 525-2300.

PHYSICIAN NEEDED for taking over practice because of illness for several weeks. If pleased with the kind of work, a possibility of Associate or take-over of excellent practice. If interested call-1-618-876-5062.

FOR SALE, LEASE OR RENT

VACATION ON SANIBEL ISLAND, FLORIDA. Luxurious condominium on Gulf Beach; two bedrooms, two baths, sleeps six; air-conditioned, pool, porch; minimum rental one week. Box 194, Ann Arbor, Michigan 48108.

FOR RENT 4010 W. MADISON ST., CHICAGO—OFFICE SPACE available for Medical Doctors. Physician short area; large number of people in need of additional physicians. 1-2-3 Room Suites. Immediate Possession. Call: Illinois Property Management Corp., Mr. R. M. Ryan, Agent. 312-VA 6-4438 or 379-1133.

FOR SALE: A four year old, 20 room (plus 4 baths) clinic. Outside white porcelain, covering 4,200 sq. ft., on acre on U.S. Route 45 at edge of Harrisburg, Illinois. Also has 1,700 sq. ft. second floor apartment. Ample concrete parking. Additional doctors badly needed in area. Will sacrifice—retiring. Phone (618) 252-3454.

PROFESSIONAL OFFICE SPACE in established medical building in downtown LaGrange. A close Chicago western suburb. 4-room suite $450 per month; 5-room suite $525 per month. Pharmacy and Lab on premises. Call Ginny Dowell, 354-1855, Baird & Warner, 505 S. LaGrange Rd., LaGrange.

ELEGANCE and COMFORT in Victorian home in close Chicago—western suburb—ten large rooms—4 huge bedrooms, 2½ baths on ½ acre lot overlooking park. Spacious foyer with winding stairway. Elevator. Intercom thruout. Close to schools, train and shopping. $110,000. Call Ginny Dowell, 354-1855, Baird & Warner, 505 S. LaGrange Rd., LaGrange.

LIBERTYVILLE, ILLINOIS. New office space available Building completion scheduled for October, 1975. Lease, ownership, or partnership available. Call collect (312) 362-4740 or (312) 834-0638.

LEASE-PURCHASE OPTION—E. Huron. Victorian brownstone. Air-conditioned, carpeted, fireplaces, beautiful woodwork, modern plumbing-lighting. Ideal for group. Low net lease. A. W. Hachmeister, 1360 Lake Shore Drive. 549-5997/751-1023.

SUITE AVAILABLE, very plush, ultra modern with garden pond, skylight, etc. Densely populated area in Northwest suburb. Please contact: W. Kmiec, D.D.S., 439-1500.

DOCTORS WHY PAY RENT: Buy an 800 sq. ft. Medical suite luxuriously finished and absolutely independent in a newly completed Medical Center in Barrington, Ill., a desirable place to start a practice and to live. Ample paved parking. Just a few blocks from the future Good Shephard Hospital. Excellent terms. Write Box 852, Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chgo., Ill. 60603.

WHEATON-CAROL STREAM: The Mona Kea Professional Park, Phase III, is now available for occupancy. Undoubtedly finest offices in DuPage County. Excellent practice opportunities in many specialties. Flexible arrangements available for starting or established physicians including leasing or purchase of office condominium. Call (312) 665-9777 or (312) 665-4530. Write Doug Mains, M.D., c/o Mona Kea Professional Park, 393 Schmale Road, Wheaton, Illinois, 60187.

HOFFMAN ESTATES—Schaumburg, Illinois, Medcoa Corporation—New Medical Office Complex. See Display ad in this issue p. 81.

BLUE SHIELD REPORT FOR *Illinois Physicians*

Improved Blue Shield Coverage for Bell System Employees

Effective July 1, 1975, Blue Shield benefits for Bell System employees and their eligible dependents, were increased from payment of 80% of charges to 90% of Usual and Customary charges of physicians for covered services. An important benefit addition to this comprehensive program is coverage for treatment of medical emergencies in a doctor's office if the treatment is rendered within 72 hours of the onset of a sudden and serious illness.

Groups benefiting from this improved coverage include the Illinois Bell Telephone Company (IMS groups 51100 and 35500), Western Electric, Teletype, Bell Laboratories (IMS groups 1820 through 1835) and the AT & T Long Lines employees (Central Certification Account 90338). An exception to the 90% U & C benefit coverage is for Illinois Bell's Local Union 165. Members of this group (51100) have a special contractual 100% Usual and Customary fee payment program.

Program benefits include:

- Surgery in or out of hospital;
- Assistant Surgeon—Benefits are available for an assistant surgeon when such technical surgical assistance is medically necessary and no house staff is available;
- Medical care up to 120 days per hospital confinement. After 90 days of non-hospitalization, another 120 days benefit is available.
- In-hospital Medical care of TB, psychiatric, alcoholism and drug addiction for up to 30 days hospital confinement. After 180 days of non-hospitalization for such care, another 30 day benefit is available.
- Anesthesia;
- Maternity care, including abortions with pre and post natal care;
- Consultation in the hospital;
- Electro-Shock therapy—on an inpatient basis, outpatient basis or in a physician's office;
- Radiation therapy—treatment of disease by X-ray, radium or radioactive isotopes;
- Diagnostic X-ray and Laboratory Services—in or out of the hospital when services are consistent with diagnosis of condition.

No benefits are available for routine physical examinations.

Hospital Coverage

Bell System employees and their eligible dependents are protected by a Blue Cross hospital program that offers covered-in-full services whenever they need care in any of the more than 7,000 Blue Cross Member Hospitals throughout the country as follows:

—When hospitalized in a semi-private room, bed, board (including special diets) and general nursing care are covered in full for up to 120 days during each hospital stay (including maternity).

—When hospital stays other than those for pulmonary tuberculosis, psychiatric care, alcoholism or drug addiction are separated by 90 days or more, they are considered separate confinements.

—Up to 30 days are allowed for each hospital stay for care of tuberculosis, psychiatric care, alcoholism and drug addiction. After 180 days of non-hospitalization for such care, another 30 days benefit is available.

—Dental Surgery—benefits for registered inpatients for dental surgery only when such treatment is a direct result of an accidental injury, removal of impacted teeth, or when a physician certifies that hospitalization is necessary to safeguard the health of the patient because of the existence of a specified non-dental organic impairment.

Reminders to Speed Claims Payments

Please ask the patient to present his Bell System

(Continued on reverse side of page)

New Coverage for Bell System Employees
(Continued)

Identification card. Information taken directly from the card, i.e. subscriber name, identification prefix letters and numbers, and group number, will help in establishing his eligibility for benefits under the program.

(1) Use Blue Shield's Physician's Service Report form in submitting the claim. A special department at Blue Shield handles Bell System claims exclusively to speed claim payments.

(2) If the patient presents an Identification Card with the wording "Central Certification" in an outline map of the United States in the upper right portion of the card, *please send the claim to us*—Illinois Medical Service, 233 North Michigan Ave., Chicago, Illinois 60601. Employees and retirees of AT & T Long Lines, Bell Laboratories and Western Electric and its subsidiaries have been issued Central Certification cards. These claims should be submitted to us—the same as for locally enrolled subscribers.

(3) In completing Physician's Service Report forms for subscribers enrolled under "Central Certification", please be doubly-sure the alphabetical code such as AT & T precedes the employee's Social Security number —example: AT & T 123-45-678, followed by the Group Number 90338.

ASK BLUE SHIELD . . . ABOUT MEDICARE

Medicare Limitations on Liability of Patient or Physician

When filing for a review of a denied claim under Medicare's waiver of liability provision, section 1879 of the Medicare Law, physicians are reminded of the intent of the provision and the conditions of payment or denial that the provision covers.

The basic intent of the new provision is to protect beneficiaries from payment liability in assigned claims under certain conditions when the payment of a claim is denied by the carrier on the finding that the service furnished was not medically necessary.

The beneficiary or physician may appeal the denial to the Part B Medicare carrier(Blue Shield in Cook County). If the carrier affirms the initial finding that the services were not medically necessary, the carrier determines if the patient and the physician were aware that such services were not covered so that the following payment action may be taken:

(1) Patient Knew Services Were Not Covered. In this situation, Medicare will pay neither the patient nor the physician. The physician, however, may seek reimbursement directly from the patient.

(2) Neither Patient Nor Physician Knew of Non-Coverage. When the carrier determines that neither party could be expected to know such services *were not covered*, Medicare will reimburse the physician for the services if he has not been paid. If the patient paid the physician, Medicare will reimburse the patient, less any portion of the patient's unpaid Part B $60 deductible and coinsurance.

(3) Patient Did Not Know, But Physician Did. When the patient did not know, but the carrier determines that the physician did know (or could be expected to know) that services furnished are not covered, Medicare will not reimburse the patient or physician. The physician may not collect payment for such services from the patient. If the physician has already collected payment, he should make refund. If he does not make refund, the carrier will reimburse the patient and then collect the amount from the physician—either directly or by offsetting the amount against future claims payments.

Generally, the carrier's determination on whether the physician knew (or could be expected to know) that such services are not covered will be based on whether the physician has ever previously been informed that certain of his services are of the type that are not covered because they are not medically necessary.

Lab Certification and Address Changes

The Social Security Administration has certified the following laboratory for participation in the Medicare program:

Northwest Medical Arts
Laboratory and X-ray
1100 Central Avenue
Arlington Heights, Illinois 60004

Effective Date: March 21, 1975
Provider Number: 14-8291

These laboratories have the following new addresses:

Avenue Medical Laboratory
12717 South Ridgeland
Palos Heights, Illinois 60463

Provider Number: 14-8277

Chicago Cytology Laboratory
5201 North Harlem Ave.
Chicago, Illinois 60646

Provider Number: 14-8273

IMJ

Illinois Medical Journal

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When Big Ben looks "a little off"...

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

□ Found useful in the management of vertigo* associated with diseases affecting the vestibular system.
□ Can relieve the nausea and vomiting often associated with vertigo.*
□ Usual adult dosage for Antivert/25 for vertigo: one tablet t.i.d.
□ Also available as Antivert (meclizine HCl) 12.5 mg. scored tablets, for dosage convenience and flexibility.
□ Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets are available for nausea, vomiting and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Editorials



Post Vasectomy Babies

The other morning I got the following letter: "Dear Dr. Van Dellen: A friend of mine has had her sixth baby four years after her husband had a vasectomy. Her doctor told her that a vasectomy is not a sure way of preventing babies and that we still needed to know more about the negative results of this procedure.

"If this is true, would you please explain why vasectomy is not foolproof?

"P.S.: Incidentally, the baby is their's—no hanky panky was involved."

The counterpart of this letter can also be found in medical journals. Even though more than three million vasectomies have been performed recently in the United States, the debate over the procedure's effectiveness and over the technic of choice continues. Much of the available evidence suggests that vas ligation is a safe procedure for purposes of male sterilization. But the end results—as described in this letter are not always successful. Recanalization, although very uncommon, can and does occur.

Perhaps the explanation lies in how the procedure is done. Any time a clip or ligature is put on the cut ends of the vas deferens, the blood supply is cut off and the tissue running from the ligature to the end of the tube dies, gets gangrenous, and sloughs off. Now, the remaining parts are free to grow together again.

But despite the remote chances of failure, the use of the Weck clip to occlude the severed ends of the vas deferens still is very popular. It carries a low rate of failure and sperm granulomas. With ligature, there may be as many as three reanastomoses in 100 vasectomies. The overall failure rate is reported to be about 0.5 per cent to one per cent of patients.

Dr. Stanwood Schmidt of Eureka, California who has done 2,000 consecutive vasectomies without a reanastmosis prefers to cauterize the vas and insert an electrical needle into the canal to cauterize the mucous membrane.

Vasectomized rats showed testicular damage and serum spermagglutination antibodies. Postvasectomy patients are being checked for these alterations. Studies on humans following vasectomy show no significant changes in follicle-stimulating hormone levels. Plasma testosterone and luteinizing hormones are higher. These levels rarely exceed normal adult ranges.

Certain investigators continue to have doubts about the long-term effects of vasectomy, which simply confirms that the perfect male contraceptive has yet to be found.

T. R. Van Dellen, M.D.
Editor



Pro-Banthine®
brand of
propantheline bromide

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

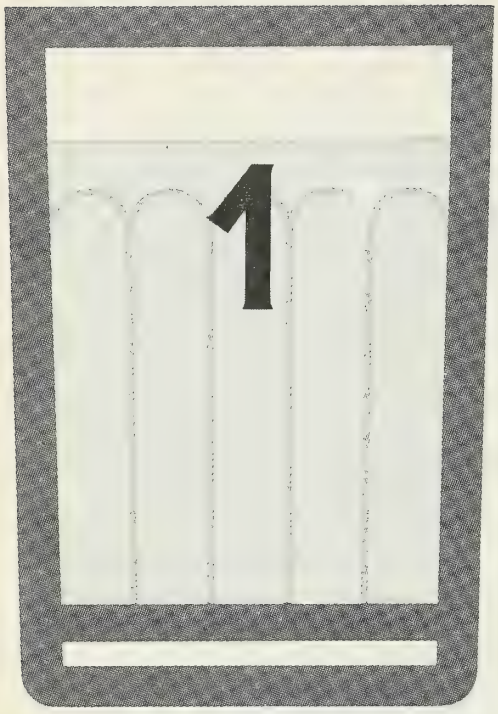
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Clinics for Crippled Children Listed for September

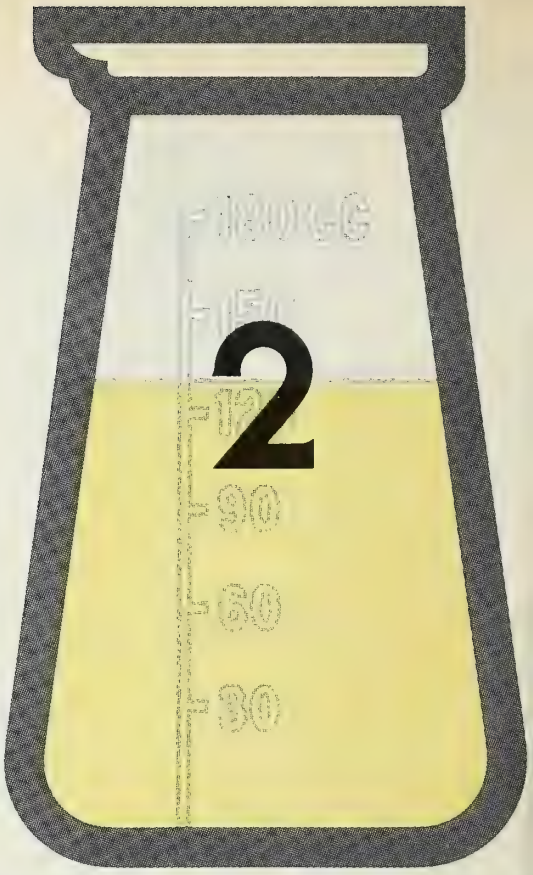
Thirty-one clinics for Illinois' physically handicapped children have been scheduled for September by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-three general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical, social and nursing services. There will be six special clinics for children with cardiac conditions, and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

September	3	Rock Island Cerebral Palsy—Foundation Crippled Children
September	3	Hinsdale, Hinsdale Sanitarium
September	4	Sterling, Sterling Community Hospital
September	4	Anna, Union County Hospital
September	4	Effingham, St. Anthony Memorial Hospital
September	4	Lake County Cardiac, Victory Memorial Hospital
September	8	Peoria Cardiac, St. Francis Children's Hospital
September	9	Carmi, Carmi Township Hospital
September	9	Belleville, St. Elizabeth's Hospital
September	9	Peoria, St. Francis Children's Hospital
September	9	Carrollton, Boyd Memorial Hospital
September	10	Joliet, St. Joseph's Hospital
September	10	Champaign-Urbana, McKinley Hospital
September	11	Macomb, McDonough District Hospital
September	11	Springfield, St. John's Hospital
September	12	Chicago Heights Cardiac, St. James Hospital
September	16	E. St. Louis, Christian Welfare Hospital
September	16	Rock Island, Moline Public Hospital
September	16	Decatur, Decatur Memorial Hospital
September	17	Evergreen Park, Little Company of Mary Hospital
September	18	Rockford, Rockford Memorial Hospital
September	18	Elmhurst Cardiac, Memorial Hospital of DuPage County
September	22	Peoria Cardiac, St. Francis Children's Hospital
September	23	Alton, Alton Memorial Hospital
September	23	Peoria, St. Francis Children's Hospital
September	24	Centralia, St. Mary's Hospital
September	24	Springfield Pediatric-Neurology, Diocesan Center
September	24	Chicago Heights, St. James Hospital
September	24	Elgin, Sherman Hospital
September	25	West Frankfort, Union Hospital
September	26	Chicago Heights Cardiac, St. James Hospital

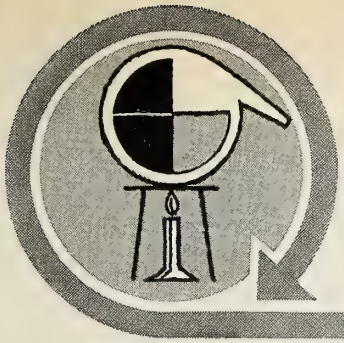
The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.



Adequate fluid intake



Frequent voiding



new pharmaceutical specialties

By Paul Dehaen

NEW SINGLE DRUGS

DIPROSONE CREAM — Local Corticoid Rx

Manufacturer:	Schering Corporation
Nonproprietary Name:	Betamethasone dipropionate
Indications:	Skin diseases responding to corticosteroid therapy.
Contraindications:	Vaccinia and varicella
Dosage and Administration:	Apply thin film to affected area morning and night.
Supplied:	Tubes, 15 and 45 Gm., 0.05%

LOXITANE — Antipsychotic Rx

Manufacturer:	Lederle Laboratories
Nonproprietary Name:	Loxapine Succinate
Indications:	Manifestations of schizophrenia
Contraindications:	Comatose or severe drug-induced depressed states.
Precautions:	Use with great caution in patients with convulsive disorders.
Dosage:	Usual therapeutic and maintenance dose, 60 to 100 mg. daily.
Supplied:	Capsules, 10, 25 and 50 mg.

DUPLICATE SINGLE DRUUGS

AZAPEN — Penicillin Derivative Rx

Manufacturer:	Pfizer Laboratories
Nonproprietary Name:	Methicillin Sodium
Indications:	Penicillinase producing straphylococci susceptible to methicillin.
Contraindications:	Hypersensitivity to penicillins
Dosage and Administration:	Intramuscular or intravenous: follow instructions in package insert.
Supplied:	Vials, 1, 4, and 6 Gm.

ISDN — Coronary Vasodilator Rx

Manufacturer:	Cooper Laboratories, Inc.
Nonproprietary Name:	Isosorbide dinitrate
Indications:	Prophylaxis and treatment of acute attacks of angina.
Dosage:	Sublingual Tablets: 1 to 2 tablets, 5 mg. every 2 to 3 hrs.; 2.5 mg. for adjustment of dose. Oral tablets: 5 to 30 mg. q.i.d., average 10 mg. q.i.d.
Supplied:	Oral tablets, 2.5 and 5 mg. Sublingual Tablets, 5 and 10 mg.

NAPHCON FORTE — Eye Preparation Rx

Manufacturer:	Alcon Laboratories
Nonproprietary Name:	Naphazoline HCl
Indications:	Topical occular vasoconstriction in conjunctivitis or occular irritation.
Contraindications:	Hypersensitivity to ingredients.
Warning:	Administer with extreme caution in patients receiving MAO inhibitors or in presence of narrow angle glaucoma.
Dosage:	One or two drops into conjunctival sac.
Supplied:	Drop-Tainer, 15 ml. 0.1%

POLYMOX — Penicillin Derivative Rx

Manufacturer:	Bristol Laboratories
Nonproprietary Name:	Amoxicillin trihydrate
Indications:	Susceptible infections caused by Gram-negative and Gram-positive organisms.
Warnings:	Do not use in patients hypersensitive to penicillins or cephalosporins.
Dosage:	See package insert.
Supplied:	Capsules, 250 and 500 mg. Oral suspension, 5 ml/125 and 250 mg. Pediatric drops, ml/50 mg.

PROCTOFOAM — Local Anesthetic Rx

Manufacturer:	Reed and Carnrick
Nonproprietary Name:	Pramoxine HCl 1%
Indications:	Anorectal anesthesia in pruritus ani, proctitis, anusitis, perianal dermatitis and hemorrhoids.
Administration:	Apply foam when needed.
Supplied:	Aerosol, 15 Gm. with plastic applicator.

NEW DOSAGE FORMS

BENISONE CREAM — Local Corticoid Rx

Manufacturer:	Warner-Chilcott
Nonproprietary Name:	Betamethasone Benzoate
Indications:	Inflammatory manifestations of corticosteroid-responsive dermatoses.
Contraindications:	Vaccinia and varicella.
Dosage and Administration:	Apply thin film to affected area.
Supplied:	Tubes, 15 and 60 Gm., 0.02%

MANDELAMINE Granules — Urinary Antibacterial Rx

Manufacturer:	Warner-Chilcott
Nonproprietary Name:	Methenamine mandelate
Indications:	Chronic urinary tract infections.
Contraindications:	Renal insufficiency.
Dosage:	Adults, 4 Gm. daily Children, 6 to 12 yrs., 2 Gm. Under 5 yrs., 250 mg/30 lbs. body weight q.i.d.

SLOW-K — Potassium Supplementation Rx

Manufacturer:	CIBA Pharmaceutical Company
Nonproprietary Name:	Potassium Chloride
Indications:	Potassium depletion and supplementation, digitalis intoxication.
Contraindications:	See package insert.
Dosage:	Adjust to requirements of patient. Prevention—20 mEq per day. Therapy—40 to 100 mEq per day.
Supplied:	Matrix containing tablets, 600 mg. (8 mEq potassium)

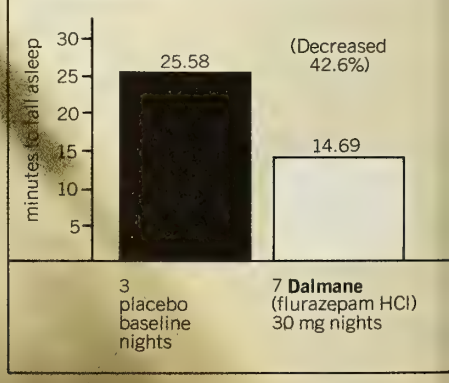


How do you handle trouble falling asleep?

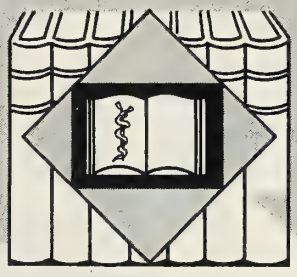
With Dalmane® (flurazepam HCl), results are highly predictable.

As demonstrated below, Dalmane induces sleep within 17 minutes, on average:[1-4]

Average Time Required to Fall Asleep [1-4]
(Four Geographically Separated Sleep Research Laboratory Clinical Studies, 16 Subjects)



the doctor's library



In my opinion, Lange Medical Publications, Los Altos, California, have put together a remarkable group of medical books dealing with many specialties. These paperback editions are as complete and current as any I have read to date.

The latest, CURRENT SURGICAL DIAGNOSIS AND TREATMENT (2nd Edition, $15.00) is well worth the consideration of practitioners and students. The table of contents contains 51 chapters on all aspects of surgery, including neurosurgery, otolaryngology, ophthalmology, urology, gynecology, orthopedics, etc.

The 1975 CURRENT MEDICAL DIAGNOSIS AND TREATMENT by Marcus A. Krupp and Milton J. Chatton is equally as complete as its surgical counterpart. These books are updated annually and are replete with charts and illustrations along with only the essential information needed by a practitioner.

A similar format is used in most of these books. The subject is introduced by 1) Essentials of Diagnosis; 2) General Consideration; 3) Clinical Findings; 4) Differential Diagnosis; 5) Natural History; 6) Treatment, and 7) Prognosis.

Since most of Lange's books are paperbacks, the price is much lower. In my library, there are no books that are as concise and up to date as these. I highly recommend them.

T. R. Van Dellen, M.D.
Editor

THE DICTIONARY OF SODIUM, FATS, AND CHOLESTEROL. Barbara Kraus. Grosset & Dunlap, New York. 1974. 366 pages. $9.95.
THE DICTIONARY OF CALORIES AND CARBOHYDRATES. Barbara Kraus. Grosset & Dunlap, New York. 1974. 388 pages, $8.95.

Barbara Kraus's two dictionaries on 1) sodium fats, and cholesterol and 2) calories and carbohydrates contain over 9,000 brand names and basic foods. These unique reference books are invaluable for physicians and patients who are on sodium-restricted, low-fat or low cholesterol diets. Items are listed in A through Z fashion with an easy-to-use cross-reference. The books have been carefully researched and THE DICTIONARY OF CALORIES AND CARBOHYDRATES is a new and revised version of "Calories and Carbohydrates."

For example, all candies are listed together, so if you are looking for Hershey-Ets, you look first under "Candy," then under "H" in the alphabetical index.

Both of these complete and comprehensive books can be recommended. They are excellent supplements to other diet books.

T. R. Van Dellen, M.D.
Editor

SICKLE CELL, A COMPLETE GUIDE TO PREVENTION AND TREATMENT by Shirley Motter Linde, M.S., 1972. Pavilion Publishing Company, 520 E. 77th Street, New York, N.Y. 10021. Paperback, 187 pages $2.00

Have you heard some searching questions from your patients about sickle cell anemia since President Nixon identified it as a "targeted disease for concentrated research" in his Health Message to Congress and several million dollars are pouring into research and treatment of the disease? Shirley Linde can answer most of their questions if you refer them to her new paperback —and you may even find a few answers for your own questions although she designed her book for the laity. The chatty text trips lightly but comprehensively over symptoms, signs, screening and diagnostic techniques, prevention, and treatment. A remarkably simplistic self-testing quiz catches the readers' attention in ways to insure bringing both those patients with the disease into a physician's hands and also the many other readers of the book through the remaining text with a feeling of personal concern for the sufferers. Although this quiz is also likely to bring patients with a lot of other diseases to attention, physicians can readily adapt to taking care of them advantageously too.

W. H. Wehrmacher, M.D.



Upjohn

ON THE FRONTIERS OF DIABETIC RESEARCH...

What is Diabetes?



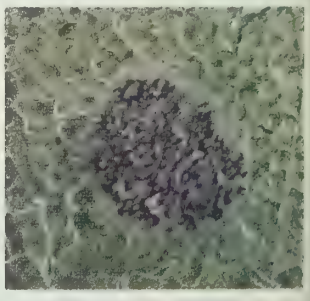
Although a medical scribe of ancient Egypt first made reference to diabetes mellitus in man, today, nearly 4000 years later, only meager specific knowledge exists as to the basic cause of the disease. Without such knowledge it has been possible to provide for limited control only *after* diabetes manifests itself in the form of elevated blood glucose. The possibility of prevention or even cure of diabetes, however, must depend on a full understanding of the genetic defect and/or defects underlying the disease. Our current understanding of diabetes may be compared to our former understanding of another disease of metabolic abnormality, phenylketonuria; only when the genetic lesion of that disease was discovered did it become possible to institute current programs of treatment.

Basic Diabetes Research at Upjohn

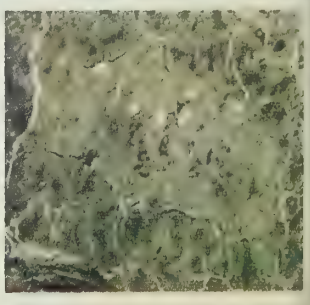
For more than ten years the Diabetes and Atherosclerosis Research Group at The Upjohn Company (W. E. Dulin, Director; G. C. Gerritsen; M. G. Soret; A. Y. Chang) has addressed itself, in a series of unique experiments, to the very basic question: What is diabetes? As with all such fundamental research, practical results are slow in coming and the work of the Group has at times raised more questions than it has been able to answer. It appears now, however, that the research is moving toward important conclusions which may, over the next several years, have significant bearing on our understanding of diabetes and, hopefully, on our ability to control it.

The Chinese Hamsters

In the middle fifties, a group studying cytogenetics in Chinese hamsters at the Children's Hospital Medical Center, Boston, Massachusetts, discovered that certain hamsters develop diabetes spontaneously. The Upjohn Research Group obtained some of these hamsters in 1962, and by controlled inbreeding, succeeded over the years in producing large numbers of diabetic animals for study. To assure continuity of the research in the event of a catastrophe, duplicate breeding stock of all the inbred families are maintained at another site. These are the only such colonies in the United States today. In the course of the research, Upjohn has cooperated with scientists in academic



Normal Chinese hamster, pancreatic tissue. Note blue-stained insulin granules which appear within the beta cells of the islet of Langerhans.



Diabetic Chinese hamster, pancreatic tissue. Insulin granules are almost totally absent. Though beta cells are present, there is some degranulization and vacuolization. The diabetic process is similar to that observed in human pancreatic tissue.

Dyrenium®

brand of **triamterene**

Potassium-sparing adjunct to furosemide in cardiac edema.

Now in 50 mg. and 100 mg. capsules.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis and nephrotic syndrome; steroid-induced edema, idiopathic edema, edema due to secondary hyperaldosteronism and edema resistant to other diuretic therapy.

Contraindications: Severe or progressive kidney disease or dysfunction (possible exception: nephrosis). Severe hepatic disease. Pre-existing elevated serum potassium. Hypersensitivity to the drug. Continued use in developing hyperkalemia. Do not give potassium supplements, either by drug or by diet.

Warnings: Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported. Check BUN and serum potassium periodically, especially in the elderly, diabetics, and those with suspected or confirmed renal insufficiency. Use in pregnancy only when essential to patient welfare.

Dyrenium (triamterene, SK&F) and spironolactone are not usually used concurrently; if they are, however, frequent serum potassium determinations are required.

Precautions: If hyperkalemia develops, withdraw the drug. The following may also occur: electrolyte imbalance, low-salt syndrome (with low salt intake), reversible mild nitrogen retention, decreasing alkali reserve with possible metabolic acidosis. Do periodic hematologic studies in cirrhotics with splenomegaly. Concomitant use with antihypertensive drugs may result in an additive hypotensive effect. When 'Dyrenium' is to be discontinued after intensive or prolonged therapy, withdraw gradually because of possible rebound kaliuresis

Adverse Reactions: Diarrhea, nausea and vomiting (may indicate electrolyte imbalance), other gastrointestinal disturbances, weakness, headache, dry mouth, anaphylaxis, photosensitivity, elevated uric acid, rash.

Note: When combined with another diuretic, the initial dosage of each agent should be lower than recommended.

Supplied: 50 mg. capsules, in bottles of 100; 100 mg. capsules in bottles of 100, in Single Unit Packages of 100 (intended for institutional use only).

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Obituaries

Axelrad, Samuel, Chicago, died June 18 at the age of 84. Dr. Aexlrad was an Uptown physician for 50 years.

***Brody, Louis,** Chicago, died June 19 at the age of 79. Dr. Brody graduated from Stritch Medical School in 1925.

Dove, Lilian, Glencoe, died June 17 at the age of 80. Dr. Dove had practiced medicine in the Chicago area for over 50 years.

***Flynn, John,** died June 17 at the age of 80. Dr. Flynn graduated from the University of Illinois in 1925.

****Francis, Charles,** Canton has passed away at the age of 79. Dr. Francis had practiced medicine for more than 50 years.

***Friedman, Morton,** Palatine, died June 13, at the age of 48. Dr. Friedman graduate from the University of Illinois in 1952. He was a past medical director of the Plum Grove Nursing Home.

***Ginnan, Edward,** died June 15 at the age of 71. He graduated from Stritch Medical School in 1929.

***Halpern, Saul,** Danville, died May 30 at the age of 62. Dr. Halpern graduated from University of Toronto in 1939.

***Hengen, Herman,** died May 31 at the age of 68. He graduated from Tuebingen, Germany in 1935.

***Kraucel, Nina,** Chicago, died April 28 at the age of 53. Dr. Kraucel graduated from Hamburg, Germany in 1948.

****Shafer, Bertha,** La Grange, died March 7 at the age of 85. Dr. Shafer graduated from Rush Medical School in 1917. She had practiced medicine for more than 50 years.

****Slott, Edward,** Skokie, died June 14 at the age of 88. Dr. Slott graduated from Chicago College of Medicine in 1917. He was on the staff of Columbus Hospital for 58 years.

***Waschick, Walter,** Kuttawa, Kentucky, died May 25 at the age of 69. Dr. Waschick graduated from Duke Medical College in 1935.

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IN GONORRHEA

INJECTION

Wycillin®

(STERILE PROCAINE PENICILLIN G SUSPENSION) WYETH

In **Gonorrhea,** the drug regimen of choice is aqueous procaine penicillin G. In uncomplicated cases, administration of 4.8 million units together with 1 gram oral probenecid, given at least 30 minutes prior to injection, is recommended.

Indications: In treatment of moderately severe infections due to penicillin G-sensitive microorganisms sensitive to the low and persistent serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

NOTE: When high sustained serum levels are required use aqueous penicillin G, IM or IV.

The following infection will usually respond to adequate dosages of intramuscular procaine penicillin G.—*N. gonorrhoeae:* acute and chronic (without bacteremia).

For deep intramuscular injection only.

Contraindication: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy.

Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen and intravenous corticosteroids should also be administered as indicated.

Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents e.g., pressor amines, antihistamines and corticosteroids.

Mental disturbances, including anxiety, confusion, agitation, depression, and hallucinations, have been reported in individuals following single-dose schedules for gonorrhea. Reactions have been transient, lasting from 15-30 minutes.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injections may produce neurovascular damage.

A small percentage of patients are sensitive to procaine. If there is a history of sensitivity, make the usual test: Inject intradermally 0.1 cc. of a 1 to 2 percent procaine solution. Development of an erythema, wheal, flare or eruption indicates procaine sensitivity. Sensitivity should be treated by the usual methods, including barbiturates, and procaine penicillin preparations should not be used. Antihistaminics appear beneficial in treatment of procaine reaction.

The use of antibiotics may result in overgrowth of nonsusceptible organisms. Constant observation of the patient is essential. If new infections due to bacteria or fungi appear during therapy, discontinue penicillin and take appropriate measures.

If allergic reaction occurs, withdraw penicillin unless, in the opinion of the physician, the condition being treated is life threatening and amenable only to penicillin therapy.

When treating gonococcal infections with suspected primary or secondary syphilis, perform proper diagnostic procedures, including darkfield examinations. In all cases in which concomitant syphilis is suspected, perform monthly serological tests for at least four months.

Adverse Reactions: (Penicillin has significant index of sensitization) skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported. (See "Warnings.")

As with other antisyphilitics, Jarisch-Herxheimer reaction has been reported.

Dosage and Administration : Administer only by *deep intramuscular injection,* in upper outer quadrant of buttock. In infants and small children, midlateral aspect of thigh may be preferable. When doses are repeated, vary injection site. Before injection, aspirate to be sure needle bevel is not in blood vessel. If blood appears, remove needle and inject in another site.

Although some isolates of *Neisseria gonorrhoeae* have decreased susceptibility to penicillin, this resistance is relative, not absolute, and penicillin in large doses remains the drug of choice. Physicians are cautioned not to use less than recommended doses.

Gonorrheal infections (uncomplicated)—Men or Women: 4.8 million units intramuscularly divided into at least two doses and injected at different sites at one visit, together with 1 gram of oral probenecid, preferably given at least 30 minutes prior to injection.

NOTE: Treatment of severe complications of gonorrhea should be individualized using large amounts of short-acting penicillin. Gonorrheal endocarditis should be treated intensively with aqueous penicillin G. Prophylactic or epidemiologic treatment for gonorrhea (male and female) is accomplished with same treatment schedules as for uncomplicated gonorrhea.

Retreatment: The National Center for Disease Control, Venereal Disease Branch, U.S. Dept. H.E.W. recommends:

Test cure procedures at approximately 7-14 days after therapy. In the male, a gram-stained smear is adequate if positive; otherwise, a culture specimen should be obtained from the anterior urethra. In the female, culture specimens should be obtained from both the endocervical and anal canal sites.

Retreatment in males is indicated if urethral discharge persists 3 or more days following initial therapy and smear or culture remains positive. Follow-up treatment consists of 4.8 million units aqueous procaine penicillin G, I.M. divided in 2 injection sites at single visit.

In uncomplicated gonorrhea in the female, retreatment is indicated if follow-up cervical or rectal cultures remain positive for *N. gonorrhoeae.* Follow-up treatment consists of 4.8 million units aqueous procaine penicillin G daily on 2 successive days.

Syphilis: all gonorrhea patients should have a serologic test for syphilis at the time of diagnosis. Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

Composition: Each disposable syringe 2,400,000 units (4-cc. size) contains procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer, and as w/v approximately 0.5% lecithin, 0.5% carboxymethylcellulose, 0.5% povidone, 0.1% methylparaben, and 0.01% propylparaben. The multiple-dose 10-cc. vial contains per cc. 300,000 units procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer and approximately 7 mg. lecithin, 2 mg. carboxymethylcellulose, 3 mg. povidone, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 1.2 mg. methylparaben, and 0.14 mg. propylparaben.

Five are graduating with honors. How many with VD?

On the average, you can figure the incidence of VD among teenagers at about 900 per 100,000 population.* And growing.

Among those in the 20-24 age-group, the incidence is even higher. And it, too, is growing.

In the long run, a populace educated to the risks and prevention of VD is probably the best answer to the problem. Meanwhile, though, adequate doses of the recommended types of penicillin remain a formidable weapon.

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High School Athletic Injuries

By Joseph F. Hinkamp, M.D./Evanston

Over a decade of experience at Loyola Academy in Wilmette has shown that active participation by the medical profession in the athletic training program can safeguard the health of the high school athlete. An interested physician and a competent trainer are not necessarily a deterent to athletic excellence. No one can guarantee a safe and efficient performance on the part of the high school athlete. However, good coaching and optimum conditioning with medical supervision can inspire confidence in one's ability to perform. There have been minimal injuries at Loyola in the last 13 years and the performance of the athletes has been outstanding.

From 1960 to 1973, over 8000 boys have participated in many types of sports at the Academy. These have included football, basketball, hockey, track, baseball, wrestling, swimming and tennis. In this period there have been no fatalities. There has been an injury incidence rate of 20% in all sports. In a contact sport the incidence of injury is 40%.

We have learned that certain aspects of our athletic program are very important:

1. Constant emphasis is put on prevention of injury.
2. Prompt medical treatment is essential even for the apparently insignificant injury.
3. Supervised follow-up care by the trainer and physician is vital.

It has been impressed on the athletes that proper body conditioning is a necessity for top performance. Mental conditioning is as important as physical conditioning because it also affects the ability to perform.

Conditioning exercises should begin in preseason training, continue throughout early practice sessions and the entire season for any sport.[1] Many athletes like to do isometric exercises to increase muscle strength, but these exercises alone do not assist range of motion or increase cardiovascular and pulmonary endurance. The best protective equipment must be used to reduce the possibility of injury. Attention must be given to proper fitting and adjustment.

Expert coaching leads to skillful performance which minimizes injuries. At Loyola Academy there is a staff of 20 coaches who are well qualified. It has been our experience, however, that without the trainer and physician, there is a tendency to neglect athletic injuries.

Though prevention is stressed, injuries do occur. Most of these injuries are minor. However, what may be minor in the medical sense may be major to the athlete whose competitive participation is temporarily limited. Care should be taken, therefore, to treat and support the emotional needs of the injured. Coaches must be taught that an injured player may suffer emotionally.

JOSEPH HINKAMP, M.D. is Clinical Assistant Professor of Surgery at Loyola University School of Medicine and Attending Surgeon at St. Francis Hospital, Evanston. He is also the Medical Consultant for Loyola Academy, Wilmette.

Areas of Injury

Loyola Academy has 1600 students. Those who compete, engage in many sports. The approximate number of players participating in each sport is outlined in Figure 1. The approximate

Figure 1

Sport	No. of Participants
Football	230
Track	80
Basketball	70
Wrestling	65
Swimming	55
Baseball	40
Hockey	30
Tennis	30
Total	600

percent of injuries incurred in each sport is shown in Figure 2. It is interesting to note that 50% of football injuries involve the lower extremity. 70% of the track and basketball injuries involve the lower extremity. Injuries associated

Figure 2

Sport	Per Cent of Injury
Football	52
Track	15
Basketball	8
Wrestling	10
Swimming	2
Baseball	8
Hockey	5

with contact and non-contact sports have been analyzed in Figure 3. Contact sports include football, basketball, hockey and wrestling. Football is a sport in which there is collision contact and can be considered separately.

Figure 3

Injury	Per Cent Occurrence		
	Sport Collision Contact	Contact	Non Contact
Contusions	60%	30%	10%
Sprains	33%	33%	33%
Fracture			
Dislocations	75%	20%	5%
Lacerations			
Abrasions	33%	33%	33%
Internal Visceral-Neurologic	90%	10%	0%

The main areas of injury are:

lower extremity	60%
upper extremity	20%
head and neck	10%
thorax	5%
abdomen	5%

50% of football injuries involve the lower extremity while 70% basketball and track injuries involve the lower extremity. There has been more prolonged morbidity with lower extremity injury.

The ankle is most commonly injured. The importance of the fibular collateral ligament in maintaining the stability of the ankle cannot be over emphasized. If this injury does not receive adequate care, it may be followed by recurrent sprains and an unstable ankle joint.

Knee injuries are second only to ankle injuries. The distinctive anatomy and function of the knee lends to its vulnerability to trauma in almost all sports. This is particularly true when the running athlete must work to receive or avoid body contact. The strength of the knee is dependent upon the bony architecture of the joint, the quadriceps muscle that acts upon the joint, the capsule, and the ligamentous structures.

Shoulder injuries occur often. Contusions are most frequent but partial separation of the A-C joint is also common. Dislocation is also possible with a complete tear of the costoclavicular and acromioclavicular ligaments. Shoulder injuries are usually sustained by a direct blow to the area.

About 7% of the injuries sustained in contact sports involve the head and neck. Athletes who engage in these sports should be given neck exercises. In a survey prepared for the National Federation of the State High Schol Athletic Association,[2] it was noted than 16 of 20 athletic deaths in 1971 resulted from injuries to the head, neck and spinal cord. The authors Blyth and Arnold point out that athletes should be given proper conditioning exercises to strengthen the neck, thus enabling them to hold their necks firmly erect when making contact. Fortunately, head injuries have not been severe. At the least suspicion of trauma to the head, contact is prohibited.

Other Trauma

Bone bruises occur and are due to severe trauma. There is no fracture, but the periosteum may be torn with hematoma and intense pain. X-rays are mandatory to completely evaluate any injury.

Shin splints is another athletic affliction. It occurs in runners. It is caused by over use of the muscles of the legs. There is swelling of the anterior compartment from the accumulation of

metabolites. Treatment is rest with resumption of activity carefully supervised.

There has been no intrathoracic or interabdominal trauma which has required surgical intervention in the last 13 years. Contact sports have produced many contusions of the chest and abdomen. It has been difficult to rule out more serious injuries at times. Rib fractures have not been common. Skin wounds have accounted for about 15 of the injuries. Abrasions, lacerations, blisters and collositas (with or without infection) have resulted in persistent disability. Herpes and staphylococcus have caused infections in wrestlers. Antibiotics are not usually needed to treat infections.

Utilization of Physician and Trainer

Adequate medical care is vital to prevent and control athletic injuries. In many high schools there is a failure to use the physician in the athletic program. In a recent survey by *Consultant Magazine,*[3] opinions of 228 doctors were reviewed. 85% favored contact sports in high school, yet 72% stated there was not sufficient utilization of the physician to minimize injury.

For efficient care of the athlete it is of utmost importance that understanding and cooperation exist between the trainer and the physician. In order for them to work together communication is mandatory. The professional competence of the trainer should be recognized.

Since Loyola has had a trainer the injury incidence rate has not changed. However, the length of disability after an injury has decreased 50%. Our trainer has had excellent rapport with the coaches and the athletes and now treatment is started early.

Judicious medical care after an injury will insure minimal disability and an early "reentry." Wound healing in athletic injuries is similar to that seen in surgical wounds, but there is more tearing of tissues, hemorrhage and edema in athletic wounds. All phases of wound healing may ocur spontaneously as Altmeier has noted.[4] Inappropriate activity and premature exposure to re-injury can retard the healing process and prolong disability.

Definitive therapy has been used for serious injuries. Rest and physical therapy have been adequate for the minor ones. We have found the cryotherapy has been most valuable in decreasing the degree of post traumatic hemorrhage and edema which occur after sprains, strains and contusions. This fact has been stressed by Olson and Stravino.[5] Cryotherapy is used immediately on most athletic injuries.

Conclusion

The high school athlete is distinct. He has emerged from the grammar school boy and wants to show himself. He is not mature in a physical and emotional sense. He needs direction to avoid injury and develop excellence and yet he may not know it. An interested knowledgable physician can help with this development.

At Loyola the trainer and the doctor have proved no deterant to athletic excellence. Since 1960, the performance in all sports has been outstanding, especially in football, track and swimming. ◄

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That Endoscope Again

Although up to two hours may be required to carry out endoscopic pancreatography or cholangiography, or both, the procedure so far appears to be without serious risk. Certain contrast mediums, however, may be more hazardous than others in that they are more apt to promote conversion of trypsinogen to trypsin. A few patients may have abdominal pain and mild fever after the procedure. Bacteremia has been reported. Serum amylase levels are frequently elevated after pancreatography, and if the volume or force used in injecting contrast medium is sufficient to opacify the finer radicles of the pancreatic duct, or even the mass of acinar ductules, subsequent serum amylase levels may exceed twice the upper limit of normal. Thus, a serious case of pancreatitis may sooner or later be expected. (F. J. Inglefinger: "Endoscopic Pancreatocholangiography: Progress and Problem." *New England Journal of Medicine* (Oct. 26) 1972 (Editorials), pgs. 879-880.)

Cholecystitis and Cholelithiasis

Appraisal of Current Treatment

By Rudolph W. Roesel, M.D., F.A.C.S./Chicago

Since the first cholecystectomy was performed by Langenbuch[1] in 1884, basic concepts of cholecystectomy have changed little. Early authors on the subject, such as Courvoisier,[2] and Kümmel,[3] reported large series of cholecystic disease with severe complications, such as multiple fistulas to internal organs, including the bronchus, urachus, and the ureters. These complications are relatively rare occurrences today. Although the basic operation of cholecystectomy is essentially the same, indications for operative intervention have changed.[4]

Diagnostic methods for cholecystic disease improved beginning from clinical observation alone to cholecystogram and intravenous cholangiogram, with emphasis on predicting complications in the future.[5,6] The term, "preventive surgery"[7] may become more meaningful regarding the treatment of cholelithiasis as has "preventive medical treatment" become promising and real.[8]

Material and Methods

This study concerns 355 patients with cholecystic disease, operated upon by the author at Augustana Hospital and Ravenswood Hospital in Chicago since 1967. There were 294 female and 61 male patients in this group, a ratio of 5 to 1. There were 55 patients under the age of 30; 254 in the 30 to 70 year age group; 41 in the 70 to 80 year age group; and 5 patients 80 years of age and more. (Fig. 1.) As indicated in Figure 1, the relatively early occurrence of cholecystic disease and cholelithiasis in this group is evident.

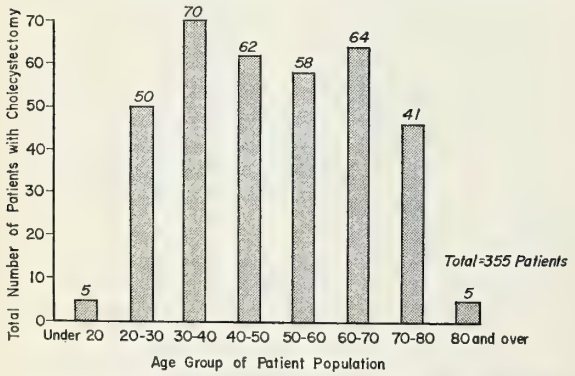


Figure 1. Age groups of patients with cholecystectomy.



RUDOLPH W. ROESEL, M.D., is an Attending Surgeon at Augustana Hospital and Ravenswood Hospital. He is also a Clinical Assistant Professor in the Department of Surgery at the University of Illinois.

Results

Our series included 20 patients with acute cholecystitis and 29 patients with subacute cholecystitis. Since there is no clinical distinction possible between the two categories, except by history, the pathologist's description of the surgical specimen was ultimately relied upon for purposes of classification.[9]

Frequently evidence of hemorrhage into the gallbladder wall or clinical evidence of inflammation of the gallbladder with local hyperemia and edema, were factors to be considered thereby.

A number of patients in our series underwent cholecystectomy in the presence of high fever and severe infection. The prompt normalization of body temperature after removal of the severely diseased gallbladder was most impressive.

During the last five years, in uncomplicated cases of chronic cholecystitis and cholelithiasis, we have employed a relatively short skin incision of 7 to 10 cm., barely able to admit the hand into the abdomen. (Fig. 2.) If possible, a cone-shaped retractor, which permits only Hartmann's pouch, cystic duct, and common duct area to protrude into its perforated lower opening, is used in medium sized and obese patients. Thus, limited but adequate surgical exposure can be achieved in a critical area and surgical trauma is kept at a minimum.

Our series included a large percentage of patients of Spanish extraction in the younger age group. The youngest patient was 12 years old. In this series, there were 5 patients under the age of 20 years, all with normal blood cholesterol levels. There were 5 patients 80 years of age and older,



Figure 2. Limited exposure of cholecystectomy . . . use of vascular clips.

two of whom required common duct exploration and transduodenal sphincterotomy, because of severe obstruction of the papilla. One of these patients had carcinoma of the pancreas. Within this group, only one patient had an uneventful, simple cholecystectomy. Complications from gallbladder disease would seem to be the rule in patients in this older age group.

Carcinoma of the Gallbladder

Carcinoma of the gallbladder was found in 3 patients as advanced carcinomatosis with invasion of the neighboring liver. In each case, because of the presence of infection, the gallbladder was removed. Subsequently, one patient, a female aged 65 years, was treated with Cyclophosphamide by regional intra-arterial infusion via the femoral artery for 10 days. Four weeks later, at postmortem examination, the patient's liver was found to contain extensive areas of tissue necrosis. In 2 patients, carcinoma of the gallbladder was only an incidental finding. No further surgery was performed after cholecystectomy in these patients. One of these patients, a male, 74 years of age at time of operation, is still alive, two and one-half years post-operatively. The second patient, a female, 68 years of age, was reoperated two years later. The previous gallbladder incision was widely excised and two-thirds of the right lobe of the liver attached to this area was removed. The patient survived this operation for five months and finally succumbed to widespread liver metastases. More radical treatment of incidental gallbladder carcinoma appears reasonable, since there seems to be a period of relatively slow local tumor growth.[10] Immediate wide local excision of the gallbladder bed and its adjacent liver structures appears the only chance for possible cure in such cases.

Secondary Cholecystitis

Secondary cholecystitis in severe penetrating peptic ulcer disease required gastric resections and cholecystectomies in 5 patients. Three patients had large penetrating lesser curvature ulcers and, understandably, the surgical procedures were technically difficult. There was no excessive morbidity, however.

Pancreatitis was present in 5 cases of cholecystitis at time of surgery. In 2 male patients there was cholecystitis without cholelithiasis; both patients admitted to excessive drinking. In all 5 patients, cholecystectomy was performed.

Palpation of small gallstones can be difficult at time of operation. Therefore, in the presence of a nonvisualized gallbladder and pancreatitis, removal of the diseased organ appears advisable.

Internal Biliary Fistulae

Internal biliary fistulas were found in 2 patients as cholecystoduodenal fistulas. In each, the fistula was surgically closed by interrupted suture technique. Scar tissue was carefully removed. The gallbladder was removed and the papilla was tested for patency. In a 79 year old male patient, a cholecystocolonic fistula was found. Diagnosis was made by barium enema. Following cholecystectomy, a choledochostomy and transduodenal sphincterotomy were performed and the opening of the transverse colon was closed by inversion. As stated previously, the relatively rare occurrence of internal fistulas is in sharp contrast to the history of cholecystic disease, as evidenced in the earlier medical literature.[2]

Hiatus Hernia

Hiatus hernia was an incidental finding in 12 patients at the time of preoperative work-up. In 3 patients, the symptoms were suspicious for esophagitis. To reduce the hiatus hernia, a Nissen-type long gastropexy was used after cholecystectomy.

Exploration of the Common Duct

Exploration of the common duct was performed in 58 patients (36 female and 22 male), the majority in the advanced age group. Indication for choledochostomy was primarily the pres-



Figure 3. Severe sphincter spasm at surgery.

ence of an obviously enlarged common bile duct or dilated cystic duct. Typical colicy type of pain prior to surgery, associated with the operative findings of an obviously inflamed or dilated cystic duct, are strong indications for choledochostomy.[11] Palpable stones were felt in 15 per cent of these patients. Elevation of the serum bilirubin level is not always caused by intraluminal obstruction. In the presence of clinical, obvious gallbladder inflammation, a subsiding serum bilirubin level is more likely caused by extrinsic pressure against the common duct. It should not necessarily be considered a deciding factor for choledochostomy. In this category, a number of negative explorations were inadvertantly carried out. The so-called ball-valve mechanism, caused by the presence of one or more fairly large free-floating gallstones, may cause similar changes, with ascending cholangitis, pancreatitis, and changing bilirubin level.

Probing and irrigating the common duct with normal saline solution is still the most effective method to mobilize, dislodge and remove calculi. The use of brushes or a Fogarty catheter is not superior to generous amounts of irrigation fluid. Operative cholangiography was used in 17 patients and proved quite helpful when positive findings could be demonstrated.

The frequent sphincter spasm after mechanical dilatation is a disadvantage of operative cholangiography, preventing a free flow of heavy contrast material and producing false negative findings. (Fig. 3.) This disadvantage is more annoying than the occasional misinterpretation of an air bubble for a gallstone. Kinks of the common bile duct, caused by a foreshortening of the hepatoduodenal ligament, as the result of chronic inflammatory changes, also produce filling defects which could be misinterpreted as residual gallstones. (Fig. 4.)

The initial probing of the common bile duct with a No. 2 Bakes dilator,[12] should lead to definite passage of the instrument into the duodenum, after a short period of resistance through the papilla. The tip of the instrument should become clearly visible through the anterior duodenal wall. Frequently, the papilla moves with the tip, the tip riding on the sphincter. The following larger probes again will not pass and may easily create a false passage posteriorly, leading to bile peritonitis. The classical sensation of the sudden release of the tip of the probe, after passing the sphincter, still appears to be the most useful sign.



Figure 4. Shortening of hepato-duodenal ligament causes filling defect in common bile duct.



Figure 5. Same patient one week postoperative with free flow of bile.

Transduodenal Sphincterotomy

Transduodenal sphincterotomy was performed in 11 patients in whom no definite passage of the probe could be demonstrated. In general, this technique is indicated in papillary fibrosis, stenosis, recurrent common duct stones, or deeply imbedded stones inaccessible for removal from above.[13] Probing and exploration is then performed from below. Only once could a large stone not be removed through the widened papilla and extraction from above became necessary. The danger of ascending cholangitis after sphincterotomy appears overrated, if proper technical precautions are taken. Free flow of bile into the duodenum is the optimal condition for prevention of ascending infection. Long limb T-tubes have been used on occasion with no adverse effect, but are not necessary in most instances. Cholecystectomy is indicated in all patients after transduodenal sphincterotomy, because of the disturbed inter-relationship between sphincter and gallbladder contractions.

Complications

There was one case of severe postoperative wound infection with marked elevation of body temperature, reddening of the skin around the incision, a small amount of drainage from the skin area, and with negative wound cultures. The incision eventually healed by secondary intention. One patient required a partial reopening of the incision due to persistent drainage, which was caused by a segment of a Penrose drain which apparently had sequestered. A 72 year old, mentally disturbed, male patient suffered an arterial occlusion of the femoral artery after cholecystectomy, and excision of two large duodenal diverticuli. There was some postoperative pancreatic drainage. The arterial occlusion necessitated an above-knee amputation of the right leg.

In 9 patients there was evidence of postoperative pneumonitis of varying degrees of severity. All responded to antibiotics and required no prolonged hospitalization. Obvious cardiovascular disease, requiring medical consultation and postoperative care, was found in 15 patients. A case of troublesome continuous bleeding from the gallbladder bed required through-and-through suture ligation of the lower part of the liver at reoperation.

Mortality

There were 5 deaths in this series related to surgery of the biliary system within 30 days after operation. The total mortality in 355 patients was 1.4 per cent. This compares favorably with the 3.6 per cent mortality figures of Rosi and Midell.[14] Of these were two patients operated under local anesthesia, in desperate condition. An 82 year old man had obstructive jaundice, later proved to be due to carcinoma of the pancreas. A second very obese male patient, age 59 years, with empyema of the gallbladder, underwent a cholecystostomy under local anesthesia after intensive medical management for heart failure and advanced renal disease; he died.

An 80 year old female patient showed signs of intermittent small bowel obstruction and cholecystitis. Despite a relatively uneventful cholecystectomy, the patient developed renal failure in the immediate postoperative period and died 18 days after operation. The fourth death occurred in a 74 year old obese female patient who had only mild jaundice upon admission. While in the hospital for clinical work-up, she suddenly developed severe abdominal pain, requiring an emergency operation on suspicion of a visceral perforation. At operation there was evidence of bile peritonitis and a severely necrotized gallbladder which had perforated near the cystic duct region. A

cholecystectomy and choledochostomy was performed. Postoperatively, the patient developed renal failure. Death occurred following a sudden massive upper gastrointestinal hemorrhage.

The fifth death occurred in a 67 year old female patient who previously had undergone a cholecystotomy for severe cholecystitis. Intermittently, the patient showed evidence of febrile disease, right upper quadrant pain and nausea. At operation her gallbladder was difficult to locate and seemed to be displaced posteriorly, below the right lobe of the liver. It is assumed that death was caused either by bile peritonitis or pancreatitis, following the operation.

Eliminating the first 2 rather desperate cases, the remaining 3 deaths would represent an adjusted mortality rate of 0.85 per cent. None of the truly elective cholecystectomy patients died after surgery.

Discussion

Clinical distinction between acute, subacute, and chronic cholecystitis has become less meaningful, since it is our policy to operate all patients, whenever possible, at the time of their first hospitalization. This is based on the experience that, more often than not, we were confronted with subacute cholecystitis rather than acute cholecystitis, as suspected by clinical history.

Primary dissection of the gallbladder from the liver bed first is important in cases of acute and subacute cholecystitis. Anatomical identification of cystic artery and cystic duct can be made easier, after the fundus and corpus of the gallbladder have been mobilized and traction applied thereto. Finger compression of the cystic duct area eliminates tissue swelling in this critical region, so that the dissection of the cystic duct and cystic artery becomes relatively easy.

Would the term "preventive surgery" in cholelithiasis be correlated with experience gained in the surgical treatment of appendicitis, even the relatively asymptomatic gallstone patient should undergo cholecystectomy. In theory, the recent experimental employment of bile acids[8] to dissolve cholesterol stones may prevent stone formation in a certain population group. However, it is unlikely that this will eliminate the present method of operative treatment for all gallstones which are not dissolvable and probably not for those cases of cholelithiasis which contain calcium layers.

The cholecystectomy of the future will be performed more in the earlier phase of the natural history of the disease and in less complicated cases. Vascular clips are presently used successfully instead of suture ligation of the cystic duct and cystic artery. These steps point in the direction of limited surgical trauma and thereby fewer post-operative complications. While limited gallbladder incisions might be hazardous, they can always be extended if necessary. The combination of limited surgical exposure by the use of a modified retractor, and vascular clips, have made cholecystectomy a simple surgical procedures in many cases, comparing well to the limited trauma of appendectomy. These facts, ultimately, should be considered regarding the choice of treatment for cholecystic disease.

Differential diagnostic problems may relate to coronary heart disease. Active coronary heart disease was encountered in several male patients. Depending on the internist's advice, cholecystectomy should be deferred in the acute and subacute phase of coronary heart disease. Real diagnostic difficulties often exist due to electrocardiogram changes. The team approach appears the logical answer in the decision-making process.[7]

Differential diagnosis of appendicitis versus gallbladder disease has become less problematic during recent years. With the emergency intravenous cholecystogram as a diagnostic aid, a more definitive pre-operative diagnosis can nearly always be made. Prior to the present series, we performed appendectomy frequently at the time of cholecystectomy. Pathological changes in the recovered appendices, however, were too infrequent to justify the continuation of this combined procedure. In an urban population center, sophisticated medical care is readily available, should appendicitis occur at a later date. The limited incision which we are presently using in uncomplicated gallbladder surgery does not permit appendectomy. No disadvantage has been experienced by following this course of action. If diagnostic doubts remain, it is better to explore the appendix through a McBurney incision first and then approach the gallbladder through a short subcostal incision.

Summary

Retrospective assessment was made of 355 operations for cholelithiasis. Trends toward early, less traumatic, well-tolerated surgery are evident. Acute and subacute cholecystitis are managed in a similar fashion to cases with chronic cholecystitis. Prompt surgery, after adequate diagnostic work-up, is performed as soon as the patient's general condition permits. Cholecystotomy as an alternative procedure for cholecystectomy is rec-

ommended in poor risk cases and should not be resorted to only in desperation.

Routine appendectomies are not performed unless clearly indicated on clinical grounds. Concomitant appendicitis appears very infrequently and was found in only 3 patients in our series. There was a total mortality of 1.4 per cent and an adjusted mortality of 0.85 per cent. Post-operative complications were usually related to advanced disease, advanced age, and a combination of both. Delay of operation in subacute cholecystitis appears no more justified than delay of appendectomy in subacute appendicitis. ◄

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Idiopathic Enlargement of the Heart: A Historical Notation

By Ronald D. Greenwood, M.D.

In 1895, Dr. Robert Babcock, Professor of the Diseases of the Chest and Clinical Medicine at the College of Physicians and Surgeons in Chicago, accumulated a number of cases of heart disease over a one year period ending November 1, 1894. Of these, 15.4% were felt to be iodipathic enlargement of the heart. He concluded in the February 1895 issue of the Western Medical Reporter published in Chicago:

> By idiopathic enlargement of the heart is meant combined hypertrophy and dilitation, without valvular disease. The primary condition is not fatty degeneration, which bears no definite relation to the clinical phenomena. The disease results from prolonged high arterial tension, and is observed most frequently in men with large chests and a tendency to corpulence. Abnormal arterial tension may arise from excess in food and drink . . . and from severe labor combined with immoderate use of alcohol and tobacco. The diagnosis is not difficult if one remembers that in these large chests actual cardiac enlargement may coexist with a superficial precordial dullness, confined within the so-called normal limits. The first indication for treatment is the lessening of the abnormal arterial tension, which is most readily done by means of cathartics and regulation of diet and exercise. Digitalis is harmful, except in cases in which the weakness is confined to the left ventricle. In cases of general cardiac enlargement and weakness, stimulants are called for, such as ammonia, nitroglycerin, ether, valerian, etc. The hypodermic injection of 1/10 of a grain of Morphine combined with 1/200 of atropine is the most efficient stimulant in cases suffering from nightly attacks of cardiac asthma. The Schott treatment, by baths and gymnastics, seems specially serviceable in this affection before compensation has become irretrievably lost.

Although much of the treatment and theory is not correct, some of these statements have great insight into the disease. At this time there were about 8000 practitioners in Illinois; the Western Medical Reporter was one of the major area publications. The Illinois Medical Journal was officially begun in 1899.

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Sideropenic Dysphagia

By Edwin E. Goldberg, M.D./Decatur

A case of sideropenic dysphagia is presented. The clinical and pathological aspects of the syndrome are discussed. Its relationship to post-cricoid carcinoma, and its possible occurrence following partial gastrectomy are stressed.

The association of long-standing iron deficiency anemia with difficulty in swallowing has been known for almost sixty years. The syndrome is usually referred to, in the American literature, as the Plummer-Vinson syndrome, and in the British literature, as the Paterson-Brown Kelly syndrome. In the Scandanavian literature, it has been called the Kjellberg-Waldenstrom syndrome. Eponymic priority has been the subject of considerable discussion, and Ormero[1] gives the distinction to the two British laryngologists.

To avoid confusion, the syndrome has more recently been referred to as the post-cricoid dysphagia syndrome and the sideropenic dysphagia syndrome. The latter, I believe, is the preferable term, since it emphasizes the two most salient features of the syndrome. The syndrome has been reported in hypochromic anemia of various causes. The occurrence of sideropenic dysphagia following partial or total gastrectomy is not well known, in spite of the high incidence of iron deficiency anemia following these procedures.

Case Report

A 46-year-old white female was admitted to Decatur Memorial Hospital on June 22, 1973, with a one month history of dysphagia, esophageal burning, "I just burn from my mouth to my stomach," and recurrent post-prandial vomiting.

In February, 1967, the patient underwent a vagotomy and local excision of a gastric ulcer. Because of persistent bleeding, the patient had a Heineke-Miculicz pyloroplasty later that month. In May of 1967, because of recurrent bleeding, the patient underwent a subtotal gastric resection, anterior polya type, with a Hofmeister modification. Her final operation was on April 3, 1969, when the old gastrojejunostomy was taken down and a gastroduodenostomy was made. Intestinal continuity was re-established with an end-to-end jejunojejunostomy.



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Admission Studies

Physical examination on admission was unremarkable except for marked pallor and the presence of numerous surgical scars on the abdomen. Blood pressure was 132/60 mm Hg., left arm, supine. Pulse was 96 and regular, and temperature was 37C. Urinalysis, serum calcium, inorganic phosphorus, glucose, blood urea nitrogen, uric acid, cholesterol, total protein and albumin-globulin ratio, total bilirubin, alkaline phosphatase, lactic dehydrogenase, serum glutamic oxalacetic transaminase, and electrocardiogram were all within normal limits. Chest roentgenogram revealed moderate cardiac enlargement with a cardiothoracic ratio of 52%. While in the hospital, repeated stool examinations for blood were negative.

Admission blood count revealed a hemoglobin of 4.8 gm/100 ml., hematocrit 17%, normal white blood cell count and differential, and normal platelets. The red blood cells showed hypochromia, microcytosis, anisocytosis and poikilocytosis. Serum iron was 19 ug/100 ml. (normal 70-170) and iron binding capacity was 242 ug/100 ml. (normal 250-400). A sternal bone marrow was performed three days after admission. The smears revealed a normal myelocyte-erythrocyte ratio with normal maturation of both series. The erythroid cells appeared hypochromic and microcytic. Hemosiderin granules were almost totally absent from the marrow. No abnormal cells were seen.

One week after admission, gastroesophagoscopy was performed using a fibro-optic gastroesophagoscope. Adequate visualization was obtained. No web or obstruction was found. The mucosa was noted to be atrophic, with a yellowish pallor, loss of rugae, and multiple scattered submucosal hemorrhages were seen.

Treatment

After the above studies, the patient was given two units of packed red cells and this was followed by daily intramuscular iron dextran (Imferon) therapy. The patient responded dramatically and within ten days her dysphagia and vomiting had completely disappeared. Serum iron at this time was 69 ug/100 ml. (normal 70-170) and her iron binding capacity was 325 ug/100 ml. (normal 250-400). She showed continued improvement and was discharged one week later on oral iron therapy.

Comment

Plummer, in 1914, and later his assistant, Vinson,[2] at the Mayo Clinic, first described a series of patients with long standing iron deficiency anemia, difficulty in swallowing, and frequent splenomegaly. Since that time, the symptom complex has been greatly expanded. Historically, in 1919, at a meeting of the Royal Society of Medicine, Paterson[3] stressed the fact that the great majority of his patients were women who had glossitis, pharyngitis, and angular cheiletis. He specifically mentioned the occurrence of post-cricoid carcinoma in patients with longstanding symptoms. At the same meeting, Kelly[4] noted the frequent occurrence, in this syndrome, of webs, scars, and adhesions just above the post-cricoid opening of the esophagus.

Since that time, there have been numerous reports of the syndrome occurring in a host of different situations, frequently with bizarre symptoms. Glossitis, loss of teeth, and toothache frequently cause the patient to seek dental care, at which time the condition is first discovered.[5] Dysphagia, as a presenting symptom, is frequently the reason that these patients are seen first by laryngologists, as originally noted.[2-4] The typical spoon-shaped nails (koilonychia), frequently with longitudinal splitting, has been reported as a presenting symptom, the patient going first to a dermatologist because of fingernail dystrophy.[6] Initially, the patients are frequently diagnosed as being hysterical or neurotic.[2-4] This is especially the case since the syndrome occurs predominantly in middle aged females in whom longstanding iron deficiency occurs. It has been stated the addition of iron to commercially prepared bread has made the syndrome relatively rare in the United States.[7]

Manifestations

The epithelial manifestations of sideropenic dysphagia include wrinkling, a yellow-lemon color of the skin, spoon-shaped nails, and graying, giving the impression of premature aging. In addition, there may be chronic perleche, and angular cheilitis, giving the lips a thin fixed appearance. Koilonychia is found in 40-50% of cases.[7,8] It is most marked in the first three digits and spares the toenails. It has been suggested that iron deficiency causes a deficiency of sulfur-containing amino acids such as cystine, and this plays a role in spooning of the nails. The slower growth of the toenails may be responsible for their resistance to koilonychia.[9]

Mucosal changes affect the mouth, pharynx, and particularly the upper esophagus in women with this syndrome. Malignancy in the post-cricoid region is a frequent complication.[10] Microscopic changes consist of squamous cell dysplasia, epithelial atrophy, hyperkeratosis, submucosol-chronic-inflammatory infiltrate, atrophy and degeneration of the underlying muscle.[7,11]

Entwistle and Jacobs[12] have pointed out the following outstanding histological features:

1. Essentially normal epithelium in post-cricoid webs,
2. Basal-cell irregularity, in situ with invasive carcinoma in many of the lesions,
3. Marked inflammatory reaction in the lamina propria
4. Degenerative changes in striped muscles and nerves

Leukoplakic mucosal changes predominately involve the oro-pharynx, but squamous dysplasia involving the mucosa of the upper respiratory tract, colon, rectum, and the vagina has been described.[7,13] Other unusual manifestations include splenomegaly, paresthesias and mental aberrations.[14]

Fundamental Characteristics

Post-cricoid dysphagia is a cardinal and distinguishing feature of the syndrome although its etiology has never been clearly defined. Kelly originally described this as being due to "spasm at the entrance of the esophagus."[4] Later the presence of delicate membranous webs, broad cuff-like strictures, adhesions, and small mobile folds of the mucous membrane were found to be associated with the syndrome. More recently, it has been pointed out that involvement of local nerve tissue in the epithelium[15] may cause muscular weakening and impairment of reflex opening of the pharyngo-esophageal junction.

This, in conjunction with the frequent presence of atrophic changes in the lower part of the pharynx in severely anemic and weak patients,

may cause subjective symptoms of "choking spells," food sticking, or matter lodging in the throat.[16] The increased masticatory effort involved in "small swallows," and the frequent restriction of the diet to soft foods and liquids low in protein, may cause further debility. Suzman has stated, "It seems superfluous to predicate spasm or achalasia as an explanation of the difficulty in swallowing in the so-called Plummer-Vinson syndrome, when a definite cause for obstruction, namely, webs, bands or raised folds of mucous membrane, is so often apparent."[17]

The presence of these "Paterson-Kelly Webs" or "Plummer-Vinson Webs" has, however, a quite variable relationship to dysphagia, being reported between 8.4% and 22.4%.[18] They may be seen on esophagoscopy, routine barium swallow examinations or more accurately with cine radiography. Nevertheless, observer error in the radiological diagnosis of webs is relatively high even in skilled hands.[19]

Atrophic Changes

The significance and importance of the atrophic changes of the upper esophagus seen in this syndrome, and the high incidence of post-cricoid carcinoma in females is well documented. Originally noted by Paterson in 1919, it was stressed by Ahlbom in 1936, and has been repeatedly emphasized since that time. It is the only part of the gastro-intestinal tract in which carcinoma is more common in females.

The actual incidence is difficult to assess because there seems to be a relationship between the duration of the dysphagia and the presence of carcinoma. It has been suggested that irritation due to food stasis above the web or constriction may be a factor in malignant change.[20] Additionally, there is evidence that correction of the iron deficiency results in a return of the histological features towards normal.[7]

In 114 cases admitted to the Radiumhemmet, Stockholm, Sweden, with Plummer-Vinson dysphagia or cancer, 81% had cancer of the upper respiratory tract, the most common site being the hypopharynx.[8] Jones,[7] in a review of the literature states that malignant changes in the epithelium have been reported in 10-30% of cases. Ahlbom found that nearly one half the women with carcinoma of the hypopharynx and upper esophagus suffered from the Plummer-Vinson syndrome.[10]

Etiological Classifications

The etiology of iron deficiency anemia in the sideropenic dysphagia syndrome is not apparent in many cases. Achlorhydria is frequently present, but its role in iron absorption is controversial since many individuals with achlorhydria show no evidence of iron deficiency anemia. Wintrobe[21] pointed out that achlorhydria itself is not sufficient to cause iron deficiency anemia, and that in normal circumstances, the role of hydrochloric acid in the absorption of iron "is only of minor importance." Achlorhydria may, however, be important when serum iron stores are depleted by promoting the utilization of iron. The various isoenzymes of the digestive enzyme pepsinogen are secreted as inactive proenzymes. These enzymes are most active in splitting peptide bonds within proteins at a very acidic pH (approximately 1.5-2). Thus the absorption of food iron is promoted by splitting protein bound iron in the upper small intestine.[22] The loss of the acid reducing ability of the stomach also diminishes the conversion of ferric to the more readily absorbable ferrous state.

The occurrence of sideropenic dysphagia as a complication of partial gastrectomy is rarely referred to in the surgical literature in spite of the high incidence of iron deficiency anemia as a complication of gastric resection and partial gastrectomy. In a review of the hematologic complications following partial gastrectomy, Hines *et al*[23] found an incidence of 34% of iron deficiency anemia.

The classification of iron deficiency anemia with dysphagia as a separate syndrome has repeatedly been questioned in the literature.[11] The presence of dysphagia is the only characteristic feature distinguishing this syndrome from other iron deficiency states. However, the relative rarity of the syndrome in relationship to the common occurrence of sideropenia, the characteristic clinical features, and the prompt response to successful iron therapy, argue in favor of retaining the syndrome as a distinct nosologic entity.[24]

In this regard, the occurrence of pica as perhaps another individual "biological variant" of iron deficiency anemia should be mentioned. This may take the form of clay eating or dirt eating (geophagia), ice eating (pagophagia), eating laundry starch, matches-pica which used to be a cause of phosphorus poisoning, and dried paint pica which still causes lead poisoning where lead-based paints are used.[25] It is interesting to note that in iron deficiency states the pica syndrome, like sideropenic dysphagia syndrome, responds dramatically, frequently in a matter of days, to iron therapy.

Finally, it should be pointed out that while pica constitutes a rather bizarre and exotic mani-

(Continued on page 140)

Seasonal Variations of Accidental Poisonings In Children: Illinois, 1972-73*

By Ross M. Mullner, M.S., M.P.H./Chicago

Nationally, poisonings are the most common medical emergency among young children. In fact child deaths from poisonings exceed those for poliomyelitis, measles, scarlet fever, and diptheria combined.[1] In the state of Illinois, in 1972-73, approximately 17,000 children under 13 years of age were reported to have ingested some type of poisonous substance. Further, during that same time period 37 children died from accidental poisonings.[2,3]

The objective of this paper is to analyze seasonal variations in the various types of poisons ingested by children in the state. Specifically, ten types of poisons will be compared for possible seasonal variation. The ten types include: 1) internal medicines, 2) external medicines, 3) household preparations, 4) petroleum distillates, 5) cosmetics, 6) pesticides, 7) gases and vapors, 8) plants, 9) paints, varnishes, lacquers, solvents, etc., and 10) veterinarian products.

Of the ten poison types, internal medicines are the most predominant type of poison ingested in the state, accounting for 8,482 cases (56.4%) for the two years of the study period. The next most important poison type is household preparations which accounts for 2,289 poison cases (15.3%). These two types are followed by pesticides (152 cases, 6.3%), external medicines (848 cases, 5.6%), paints, varnishes, lacquers, solvents, etc. (839 cases, 5.6%), petroleum distillates (697 cases, 4.6%), and cosmetics (621 cases, 4.1%). Lastly, plants account for 228 cases (1.5%) and gases and vapors, and veterinarian products accounts for 52 and 47 cases (0.3% and 0.3%), respectively.

Method

Data for these various poisons were obtained from the 1972-73 annual *Poison Control Program Reports* published by the Illinois Department of Public Health. These reports contain summaries of those poison cases treated at the 102 official poison control centers and numerous cooperating hospitals located throughout the state.

Two limitations of using these data sources include the fact that these reports do not contain information on those poison cases who are treated at a hospital which is neither a poison control center nor a cooperating hospital. Further, the reports do not contain information on those children who are poisoned but who subsequently are not taken to a hospital or a physician to receive care.

With these limitations in mind, a series of graphs for each of the ten poison types were constructed for the two years of the study period, respectively. Next, the two graphs for each poison were compared. If the frequencies or "peaks" and "troughs" of a particular poison for one year tended to coincide with the "peaks" and "troughs" of the same poison type for the following year a seasonal variation was assumed.

In all, three poison types were identified as having a marked seasonal pattern. The three include: internal medicines, petroleum distillates and plants.

Discussion

Poisonings due to internal medicines of all types (Fig. 1) including acetylsalicylic acid as well as other internal medicines in liquids and tablet form all exhibited a marked seasonal decline during the summer months. This decline one may conjecture is due primarily to a decrease in exposure. Children, especially one and two year olds, are spending more time outside away from medicine cabinets and dresser drawers resulting in fewer poisonings.

Poisonings due to petroleum distillates (Fig. 2) conversely, demonstrated a marked increase in the summer and early autumn months. This increase one may again conjecture is associated

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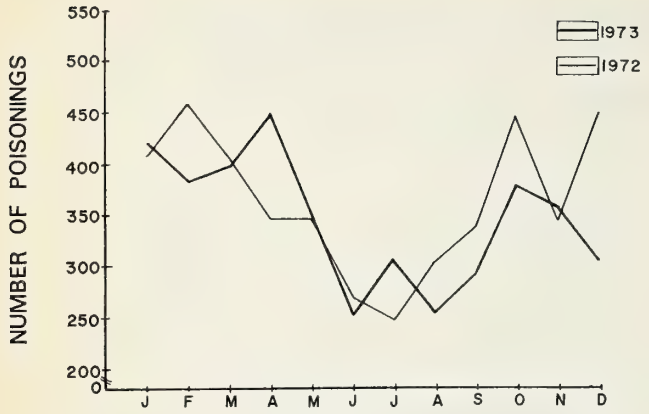


FIGURE 1. INTERNAL MEDICINE — ALL TYPES

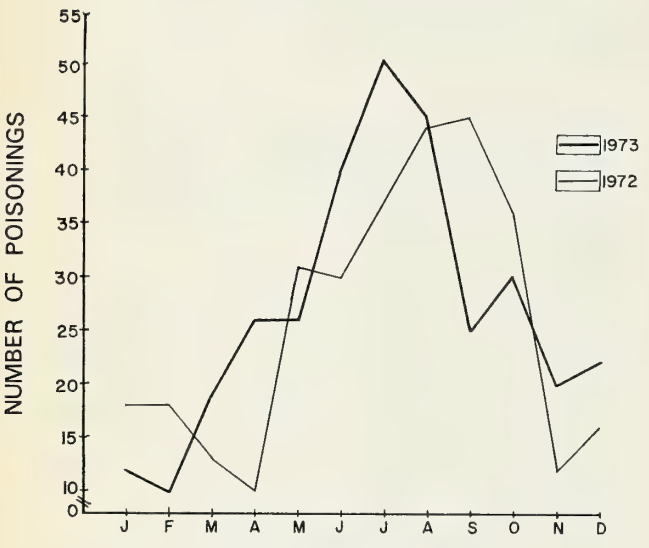


FIGURE 2. PETROLEUM DISTILLATES

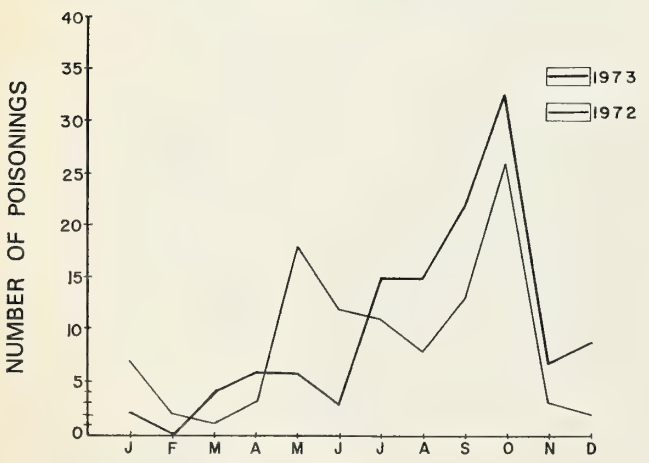


FIGURE 3. PLANTS

with an increased use of petroleum products such as gasoline for lawnmowers, boats, and power tools as well as charcoal lighter fluid for barbeques and cook-outs during this same time period.

Lastly, poisonings due to plants showed a marked increase during the month of October (Fig. 3). In fact, for both 1972-73 the greatest number of plant associated poisonings occurred during this month. To investigate the reason or reasons for this increase the specific species of plants ingested during this month were analyzed. The analysis revealed that children during this time period were ingesting berries from several plant species all of which produced toxic berries during the late fall.[4] These plants included: the Pokeweed *(Phytolacca americana),* Yew evergreen tree *(Taxus canadensis),* and Nightshade plants *(Solanum dulcamara* and *S. nigrum).*[5]

Summary

In conclusion, a marked seasonal pattern was identified for three types of poisons ingested by children in the state. The three types of poisons include: 1) internal medicines, 2) petroleum distillates, and 3) plants. Further, a series of conjectures were made in order to explain the seasonal patterns identified. For plant associated poisonings several species of plants were identified which produce toxic berries. These berries being ingested in the fall of the year.

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Sideropenic Dysphagia

(Continued from page 138)

festation of iron deficiency anemia, the presence of sideropenic dysphagia is much more serious because of its association with carcinoma of the hypopharynx. Therefore, adequate iron replacement therapy and prolonged follow-up of these cases are necessary. ◄

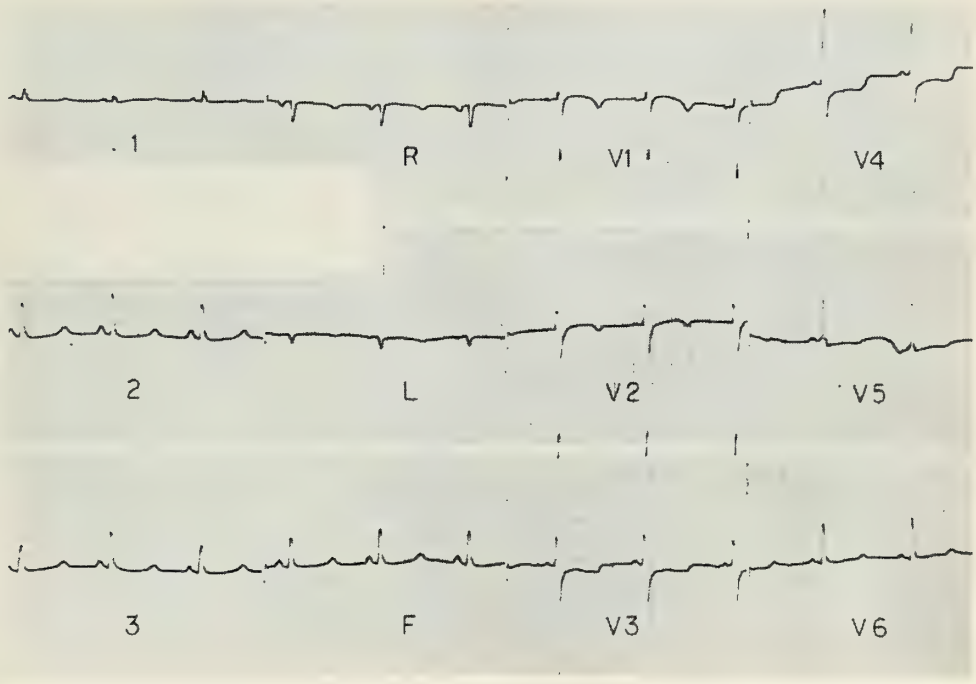
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ekg of the month

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Section of Cardiology, Department of Medicine,
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A 52 year old housewife was admitted following a bout of severe breathlessness, chest discomfort, and numbness in the extremities.



Questions:

1. The electrocardiogram taken during an attack shows:

A. Acute anteroseptal myocardial infarction.
B. Acute cor pulmonale.
C. Prolonged Q-T interval.
D. Shortened Q-T interval.
E. Prominent U waves.

2. Most likely explanation for ECG changes are:

A. Hyperparathyroidism.
B. Pulmonary embolism.
C. Hypocalcemia.
D. Hypercalcemia.
E. None of the above.

(Answers on page 153)

Localization of Occult Abscesses Utilizing Radioactive Fibrinogen

By Juan Carlos Parodi, M.D., and Demetrio Jorge Vazquez, M.D./Chicago

The precise localization of an occult abscess can be a difficult clinical problem. Indeed, an unsuspected abscess is frequently found at autopsy in spite of careful clinical observations. Cole and Zollinger[1] mention that 10% to 15% of subphrenic abscesses are first diagnosed at autopsy.

The purpose of this study was to evaluate the effectiveness of I^{131} labeled fibrinogen in detecting and localizing abscesses. Fibrin deposits regularly in the wall of an abscess. This deposit of fibrin found in every abscess varies depending upon the organism involved, the anatomic location and the patient's ability to respond.

The hypothesis this study was designed to evaluate was that intravenously injected I^{131} labeled fibrinogen would localize wherever fibrin was being deposited and that concentrations of I^{131} labeled fibrin could be detected by an external radiation detector. These deposits would, of course, have to be differentiated from those in blood vessels, extravascular spaces and in serofibrinous effusions.

Materials and Methods

We have used I^{131} labeled fibrinogen supplied by the Argentinian National Commission of Atomic Energy using for its preparation the McFarlane's technique.[2] Each 6 mg of fibrinogen contained 100 μc of I^{131}.

The dose for each patient was 300 μc administered intravenously. The day before the test the thyroid gland was blocked by the administration of IN orally. If an urgent determination was required, this medication was injected by intravenous route one hour before the test. Forty-one adult patients, both male and female, were studied. All of them were aware of the purpose of the study and its method. They were divided into three groups as a control.

Group A: 8 patients were subjected to the test in the absence of any clinical infection. Seven had had surgery with a normal postoperative course. One had not been operated upon. These 8 patients were followed for more than 3 months to be certain that no infection had existed.

Group B: This group consisted of 7 patients in whom an abscess had been surgically drained and who were tested after the drainage.

Group C: This group consisted of 26 patients who were affected by a septic state without a localized or confirmed focus.

Twenty-four hours after the radionuclide injection a detector was used to count the activity in the suspected areas. This is similar to the technique used for radioiodine thyroid uptake measurements. The detector was located in contact with the patient's skin and was left in place one minute over each point of measurement. The counts per minute were compared to the level found in the cardiac area which was arbitrarily considered to be 100%. The cardiac emission was measured on the left border of the sternum between the 4th and 6th intercostal spaces.

In all the cases the diagnosis of abscess was confirmed by means of operation or autopsy.

The diagnosis of non-existence of suppuration was based on a prolonged clinical observation and in some cases, by operation. In one case a patient belonging to the group B, 100 μc of human albumin labeled I^{125} was injected and measurements were taken 24 hours later. The patient then was tested with I^{131} fibrinogen.

Results and Discussion

Group A: (Table 1) Patients with no evidence of infection. The sites of greatest emission were recent surgical wounds, the liver, the spleen, the thyroid area and along the large blood vessels. These never exceeded 90% of the cardiac values. No other areas exhibited significant

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Table 1 (Group A)
None of these patients had either a general infections state or a local one.

Case No.	Primary Diagnosis	Maximum Count	Location of the Maximum Count
16	Cholelytiasis	72%	Operative wound
17	Duodenal ulcer	58%	Operative wound
18	Kidney stone	72%	Operative wound
19	Cholelytiasis	74%	Operative wound
20	Abdominal gunshot	90%	R.U.Q.
21	Ca of the bladder	89%	R.U.Q.
22	Chronic Epidymitis	76%	R.U.Q.
23	Portal Hypertension	78%	R.U.Q.

localization. The high emission in the recent surgical wound may be explained by the deposit of fibrin and local hyperemia. The high emission in the hepatic and splenic areas and over the large vessels may reflect high blood flow as well as incorporation of fibrin by the reticulo endothelial system. In one additional patient with hepatosplenomegaly the radioactive emission over the liver and spleen remained below 100%.

Group B: Patients with drained abscesses. In the zone corresponding to the collection previously drained, the number of counts always exceeded 100%; the values ranged between 110% and 369% with an average of 189% of the cardiac valve. The smallest abscess had a diameter of 2 cm and the location varied from subcutaneous to the retroperitoneal space.

Table 2 (Group B)
Patients with a drained abscess who were subjected to the test.

Case No.	Primary Diagnosis	Location	Maximum Count	Place of the Maximum Count
1	Abdominal gunshot	Right subphrenic space	228%	Base of the right hemothorax
2	Spontaneous Retroperitoneal hematoma	Left lumbar zone	145%	L.U.Q.
3	Strangulated diaphragmatic hernia	Left subphrenic space	136%	L.U.Q.
6	Digestive bleeding	Left pleural cavity	113%	Base of the left hemothorax
7	Retroperitoneal abscess	Left lumbar zone	369%	Left flank
9	Perforated duodenal ulcer	Right subphrenic space	110%	Base of the right hemothorax
12	Umbilical hernia	Umbilical zone	227%	Umbilical zone

Group C: Febrile patients with suspected abscesses. The results of the test were:

Negative: Thirteen cases. Eleven of these 13 patients recovered with no evidence of abscess being found after prolonged observation. Two of the 13 patients were operated upon. No abscesses were found.

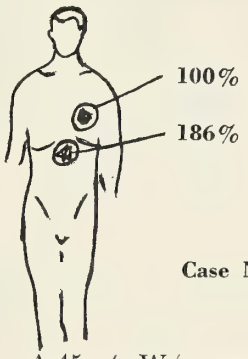
Positive: Twelve cases. In 11 of these patients an operation confirmed the presence of an abscess. The remaining patient died. The autopsy study demonstrated an abscess containing 200 cc of pus in the pancreatic area. (The radioactive emission in this area had been 357% of the one of the cardiac area).

The emission values in these positive cases varied between 103% and 355% with an average of 166%.

False negatives: 1 case. A patient with an acute appendicitis; the emission in the right lower quadrant did not exceed 100% (96%), but it was far higher than the left lower quadrant (67%) in symetrical points.

In one patient with a renal fossa abscess the localization of I^{125} albumin was compared with I^{131} labeled fibrinogen. The emission level of I^{125} albumin was 35%; the emission of I^{131} fibrinogen was 140%.

Description of a Characteristic Case



Case No. 36

A 45 y/o W/m was admitted to the Clinic with severe acute pancreatitis, associated with alcoholic ingestion. The patient did well after intensive care and was discharged one week later. After two weeks he returned to the Clinic because of fever. He had no other symptoms. Physical examination was normal except for a temperature of 38°C. The fibrinogen uptake test was carried out. Counts over the epigastric area were 186% (considering 100% the one minute cardiac counts). The patient was operated upon and 2c abscess was disclosed in the superior border of the pancreas. The patient did well after drainage.

Table 3 (Group C)

Febrile Patients with Suspected Abscesses. Negative Localization.

Case No.	Diagnosis	Maximum Count	Location of the Maximum Count	Evolution	Result
4	Abdominal trauma	50%	R.U.Q.	Operation, Hematoma was drained	True Negative
24	Gastric perforated ulcer	52%	Epigastrium	Uneventful recovery	True Negative
25	Rectal cancer	74%	Left flank	Uneventful recovery	True Negative
28	Nephrectomy of pyonephrosis	70%	R.U.Q.	Primary atypical pneumonia	True Negative
30	Febrile state symptoms of salpingitis	70%	Hypogastrium	Operation, hydrosalpin	True Negative
31	Cholecystectomy fever	84%	R.U.Q.	Uneventful recovery	True Negative
32	Febrile state hemiparesis	73%	Occipital zone	Uneventful recovery	True Negative
35	Postappendectomy fever	82%	R.U.Q.	Uneventful recovery	True Negative
36	Post-Colectomy	81%	L.U.Q.	Uneventful recovery	True Negative
37	Acute Pancreatitis	94%	Epigastrium	Uneventful recovery	True Negative
38	Posthysterectomy	80%	R.U.Q.	Uneventful recovery	True Negative
39	Posthysterectomy	82%	R.U.Q.	Uneventful recovery	True Negative
40	Post Cesarean Section	80%	Umbilical zone	Operation, ovarian cyst	True Negative

Discussion

The use of labeled fibrinogen permits one to speak about "zones with an abnormal deposit of fibrin." The presence of a greater radioactive emission than the one of the cardiac area, according to the results of this series, indicates the existence of a suppurative collection.

In a previous work we have proved that even in presence of massive venous thrombosis the radioactive emission in the affected area never rose over 60%. Moreover, in two patients of this series with hematomata the radioactive emission never exceeded the cardiac area level. With data obtained from the associated test with I^{125} Albumin and I^{131} Fibrinogen we may conclude:

1) The increase of the radioactive emission in the suppurated zone is not due to the hyperoemia, since in that case the emission would be similar with both I^{125} Albumin and I^{131} Fibrinogen.

2) The increase of the radioactive emission in the suppurated zone is not due to an increase in capillary permeability because in this case the radioactive emission with I^{125} albumin would be greater because of its smaller molecular size and its ability to leave the vascular bed.

Summary

The data obtained in this study reveal that I^{131} labeled fibrinogen is deposited in concentrations higher than that of the pre-cardiac level in abscesses as in drained suppurations. There was no localization over 90% in any patients free of infection. The emission levels over draining areas ranged from 110% to 369% with an average of 189%. In 13 patients with suspected abscesses the localized emission was below 100%. None of the thirteen patients developed an abscess. In

Table 4 (Group C)

Febrile Patients with Suspected Abscesses. Positive Localization.

Case No.	Diagnosis	Maximum Count	Location of the Maximum Count	Evolution	Result
5	Acute Pancreatitis	355%	Epigastrium	Death. At autopsy peripancreatic abscess	True Positive
8	Abdominal trauma	103%	Base of the left hemothorax	Operation, empyema drained	True Positive
11	Perforated duodenal ulcer	159%	L.U.Q.	Operation, Left subphrenic abscess drained	True Positive
14	Polytraumatism	130%	Right hemothorax	Operation, empyema drained	True Positive
15	Abdominal gunshot wound	111%	Epigastrium	Operation, peripancreatic abscess drained	True Positive
26	Acute Pancreatitis	186%	Epigastrium	Operation, peripancreatic abscess drained	True Positive
27	Prostatic adenoma	148%	L.U.Q.	Operation, left subphrenic abscess drained	True Positive
29	Acute Pancreatitis	206%	Surgical wound	Wound abscess drained	True Positive
33	Pneumopathy with pleural effusion	166%	Left hemithorax	Operation, empyema drained	True Positive
34	Pancreatic wound	105%	Base of the left hemothorax	Operation, left subphrenic abscess drained	True Positive
41	Pancreatic wound	129%	Epigastrium	Operation, Pancreatic abscess drained	True Positive
42	Perforated duodenal ulcer	119%	Base of the left hemothorax	Operation, left subphrenic abscess drained	True Positive

Table 5 (Group C)

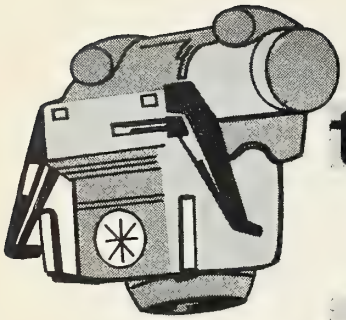
Febrile Patients with Suspected Abscesses. False Negative Localization

Case No.	Diagnosis	Maximum Count	Location of the Maximum Count	Evolution	Result
10	Appendical abscess	96% 67%	R.L.Q. R.L.Q.	Operation, drainage of a periappendicful abscess	False Negative

twelve patients suspected of harboring an abscess elevated localized emissions ranging from 103% to 355% wre found. All of these patients were found to harbor an abscess. ◄

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the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

This 25 year old female had complained of repeated bouts of chest pain, cough, dyspnea. She had also had pain in the small joints of her hands. In the past year she had had increasing pain in the hip and has developed a limp. (Fig. 1 and Fig. 2)

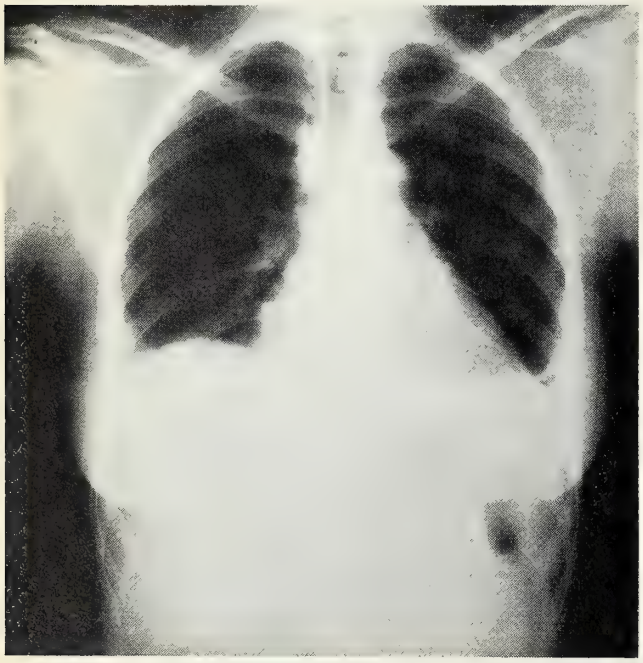


Figure 1

What's your diagnosis?

1. Tuberculosis
2. Systemic lupus erythematosus
3. Rheumatoid arthritis
4. Gaucher's disease

(Answers on page 153)

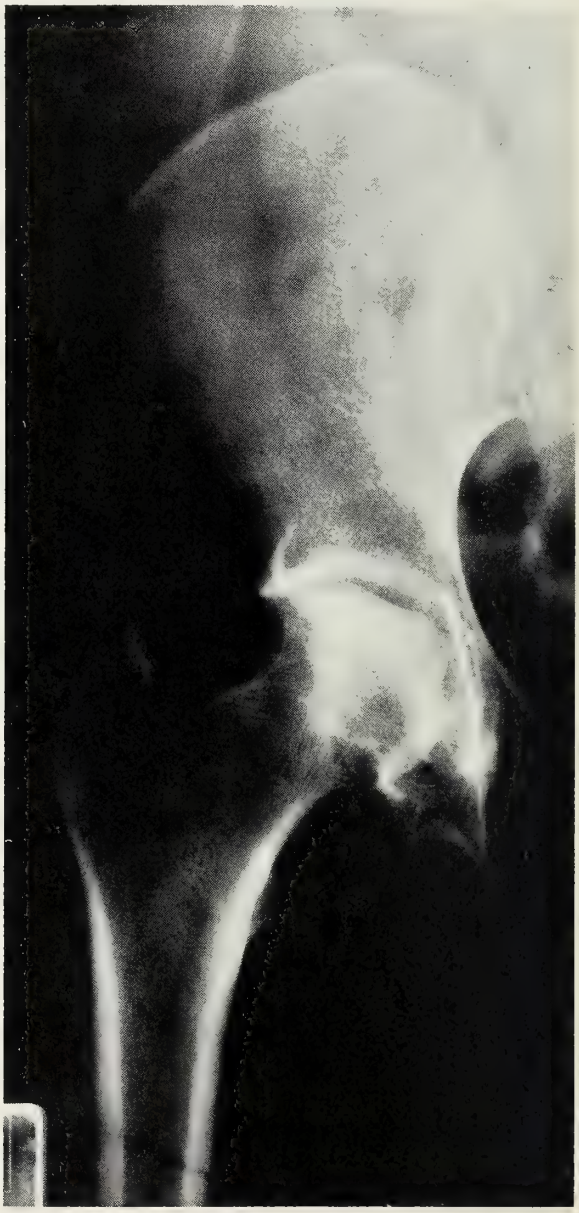


Figure 2

The Role of the Predischarge Patient Conference

By John F. Schneider, M.D. and Joseph B. Kirsner, M.D./Chicago

As the Federal Government has assumed a greater portion of the cost of health care in the United States, it concomitantly has become interested in maximizing the quality of health care delivered while minimizing the cost. A variety of standards can be utilized, broadly being concerned either with the process, or the outcome of the delivery of health care. In addition to establishing standards, the processes of judging quality need to be developed and physicians must learn how to apply the peer review process. This need may be met within the context of university teaching rounds by a predischarge conference. Such a conference would entail a review of hospitalization and establish post discharge plans for the care of the patient.

Physicians and others who provide medical care always have been concerned with maintaining high standards and quality in the care they deliver. Physicians, however, sometimes resist efforts to have their practice evaluated to determine the quality of the care provided even if that evaluation is undertaken by their peers. Concern with such means of evaluation dates back approximately 50 years to Codman[1]. In spite of sporadic concern, it has been only in the past decade, and in particular during the past year, that major interest in means and mechanisms to evaluate the quality of health care has become evident. This increasing interest was reflected in the 15th Annual Symposium on Hospital Affairs in May, 1974, which focused on "The Hospital's Role in Assessing the Quality of Medical Care."[2].

A major factor in the present interest in quality of care can be related to the observed unfavorable comparison of morbidity and mortality statistics in the United States with those of other countries as a reflection of the quality of the medical care provided here. As the poor, the black, and the aged were readily identified as special groups receiving inadequate medical care, efforts have been made through Medicare, Medicaid and other public aid groups to improve the quality of care provided them. The effects of these programs on improvement of the quality of care are uncertain but they have contributed, or at least have been affected by the rapidly increasing costs of medical care. The desire to lower costs by the elimination of unnecessary procedures, hospitalization and treatment has become a major motivation for the improvement of health care. Thus, the presumption is that better quality medical care, at least in the short run, will be less costly.

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Establishment of Standards

Professional Standard Review Organizations, as established by PL 92-603, demanded attention to the issue of quality of care, at least that provided within the hospitals. Already the Hospital Admission and Surveillance Program (HASP) in the State of Illinois apparently has demonstrated a reduction in length of stay[3]. Presumably quality and cost are related; improvement in quality leading to a decrease in cost. The experience of prepaid comprehensive plans appears to confirm this statement. Although reduced costs may be a desirable public and political goal, it provides in and of itself no direct measurement of the quality of care. However, the establishment of systems or standards whereby one can judge quality has been difficult. Starfield[4] recently has proposed a model for research into health care provisions and has provided a comparative analysis of previous proposed models. From her recommendations and the editorial comments of Sommers[5] it is apparent that systems of evaluation must be directed toward the patients themselves and preferably mechanisms which can become operable without dramatic changes in the present system.

Establishment of standards of quality care is plagued by the necessity to choose among minimal standards reflecting proven scientific evidence, ideal standards arrived at by individuals specially trained in the care of a particular disease, and the measurement of deviations from present behavior as is accomplished by HASP, utilizing Professional Activities Study data on

average length of stay. As may be obvious, the selection of standards for the evaluation of care may lead to widely different impressions of the quality of the care being provided. Brook[6] demonstrated this by a comparison of standards arrived at by group consensus regarding the process of care for hypertension with standard of outcome determined subjectively by the reviewers. In the case of group consensus, 1.4% and in the case of subjective determination of outcome, 63.2% of the patients were judged to have received adequate care. Even if one could agree on standards of care for a given diagnosis, the necessity to relate these standards to particular patients poses problems.

As Feinstein[7] has demonstrated, a multitude of factors enter into the prognosis of a patient with carcinoma of the lung. Since outcome measures of quality must reflect the effect of the care per se, such an accurate prognosis would need to be determined for each patient. Thus, individuals with a given diagnosis may require more or less hospital admissions or therapeutic care on the basis of a variety of factors including such considerations as their age, previous illnesses, and the presence of other disease states. Establishing large number of separate standards and subclasses for all diseases thus would create a very cumbersome system, even if this approach indeed were possible at the present time.

Lack of Training

No training of physicians or medical students in the evaluation of quality cost relationships exists at the present time. Development of the problem-oriented medical record has emphasized the need for ongoing critical evaluation of patient care in a system whereby some feedback mechanism exists to enable the provider of care to improve on the results of evaluation. Feinstein[8] has pointed out that the increased supervision itself generated by implementation of the problem-oriented record may meet the need, even in the present conventional format. As mentioned by Goldfinger[9], the problem-oriented record itself does not impart quality provision of care, but does provide a visible record of at least some aspects of that care. The medical record, of course, is an item which makes possible the evaluation of care without assembling the individuals who have been responsible for the provision of that care.

The Bi-Cycle Concept, developed by Clement Brown[10] is another means of generating feedback in an effort to improve provision of care, based predominantly upon needs identified by the examination of medical records. Students themselves have had no real training in this or in self-evaluation. Peterson[11] demonstrated the need and the potential use of the problem-oriented medical record as a structure whereby one can institute a system wherein students learn to audit their own and other student's records. Although the medical records systems can convey in writing essentially the totality of data and decisions involved in the care of the patient, even when very complete, the record still fails to reveal in detail the interaction of the physician and the patient and the significance of this personal interaction in terms of the care of the patient.

Conclusion

Thus, we have described several needs to be met by any system of evaluation of quality of care. Such an approach would include cost-benefit relationships, direct relationship to the patient himself or herself, broad applicability and flexibility. It would involve an educational experience for housestaff and students with the degree of immediate feedback necessary for the system to fulfill its role of education and modification of the future behavior of the providers of medical care involved.

We, therefore, suggest that these needs can be met, at least partially, by implementing a predischarge conference within the present systems of attending rounds or visits. The university hospital places its teaching emphasis on the initial evaluation, diagnosis, and the establishment of therapeutic plans for the patient when he or she enters the hospital. Lesser amounts of time are devoted by the housestaff and attending especially if no problems occur, until the patient discharge, upon completion of the original diagnostic and/or therapeutic plans. The patient then returns to be followed in one or more variety of ways as an outpatient. The defects of such a follow-up are documented by Brook.[1]

Outline of a Plan

We would suggest that the predischarge conference on all patients either be added to or replace part of the time which has conventionally been devoted to the initial presentation, discussion and evaluation of patients. As a result of the present computerization of patient charges, the costs incurred during hospitalization for the procedures performed presumably can be made available immediately preceding the discharge. This cost may then be related to the efficiency and efficacy in establishing diagnoses, defining

problems, bringing about effective therapy, and educating both patient and housestaff. Immediate feedback as well as the process of such auditing would be available and presumably would be expected to influence the future behavior of housestaff in caring for similar patient problems.

While the conference should be oriented to summarizing the events of the hospitalization, it may not necessarily result in approval of discharge at that time. If the review of the hospitalization indicated need for additional diagnostic or therapeutic intervention, the patient would remain for completion of the necessary procedures. Discussion of the case would involve housestaff, students and attending physician as he or she wished. The review by a physician not immediately involved in the patient care would maximize peer review qualities of the conference. However, when this is not practical the use of the attending physician as the director of the conference would still be considered appropriate. Others, including social service, nursing, and pharmacy personnel should be included when appropriate to the patient's problems.

The reviewer then should involve the patient in conversation resulting in a detailed review of the history and the relationship of hospitalization to the patient's problems. The purpose of this approach would be to establish the correctness and the adequacy of the diagnostic and therapeutic approach to the patient. Common initial misinterpretation of the patient's problem, such as neglect of life style, can explain inadequacies in the approach taken during the hospitalization and provide for appropriate reorientation of the clinical approach before discharge. Of course, the discussion would include examination of the patient, review of X-rays as well as laboratory data, with emphasis upon accuracy, quality and efficacy of the information obtained; clarification of questions and discussion among housestaff, students, and when appropriate the patient, about how various items can be integrated into the overall clinical pattern.

The conference would also establish the completion of patient education and insure that the patient understands future therapeutic goals as well as any further diagnostic procedures which might be needed following discharge. Frequently patients as well as housestaff and students are confused about the nature, purpose and applicability of diets and the reasons for prescribed medication, whose mode of action and purpose may be unclear. Potential problems are often not anticipated.

The nature of the follow-up outpatient care then could be established with the patient, i.e. that the patient return to the outpatient clinic of the hospital where he was hospitalized, return to the care of another physician, or some other mechanism which might be established for continuing care. A discharge statement of goals with an indication of patient understanding then would serve as a means of providing future evaluation of the effectiveness of outpatient care. Finally, the conference provides a summary of the entire hospital experience for the patient's family. It answers questions, relieves anxiety and renews hope, all of which have an important effect on improving the personal relationships between patients and physicians.

Summary

Such a predischarge conference would expose housestaff and students to the mechanism of peer review and would enable them to develop techniques and skill in these procedures. Standards of care would be evolved as the result of this process and other standards could be tested and applied while maintaining concern for the individual patient. Such a scheme could utilize the problem-oriented medical record or more conventional records since it would not be dependent upon the means by which data and impressions have been structured into the written record. It would permit additional evaluation and input by the attending staff of the skills and effectiveness of housestaff and paramedical personnel in their interaction with patients both in medical care education and in long range therapeutic planning.

Finally, such a system could serve, as previously mentioned, to establish goals for future evaluations of the effectiveness of outpatient care. Of course such a predischarge conference suffers from dependency on the skill of the reviewer or the attending physician in evaluating the patient's care. The approach is also quite subjective. However, it does not exclude the application as well as the development of more defined standards of care, and, at least within a teaching hospital, it provides a means for easily instituting ongoing evaluation of the quality of hospital care in the present system. ◄

References

A complete bibliography for The Role of the Predischarge Patient Conference may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe St., Suite 3510, Chicago 60603.

Clinical Implications of Atrial Fibrillation

By Dee C. Boswell, M.D./Centralia

Atrial fibrillation is an important cardiac arrhythmia. Its presence should indicate prompt careful clinical evaluation for underlying heart disease or thyrotoxicosis or both. Seven cases of atrial fibrillation are reviewed in this paper and their clinical implications emphasized.

Case 1

A 52-year-old woman was hospitalized in November, 1973, for progressive dyspnea and palpitations. There was no history of rheumatic fever. Physical examination disclosed an irregular apical heart rate of 120 per minute, BP 160/80 mm Hg and respiratory rate 16 per minute at rest. There was a left parasternal lift, an opening snap, a mid-diastolic rumble at the apex and a soft early diastolic blow along the lower left sternal border. EKG revealed atrial fibrillation. Chest X-ray revealed left atrial enlargement.

This patient presented with atrial fibrillation and was found to have mitral stenosis and aortic regurgitation.

Comment

Since atrial fibrillation occurs in 40% of patients with mitral stenosis, careful search for this lesion is important when atrial fibrillation is encountered. Advancing age was found to be a major contributing factor in the development of atrial fibrillation in mitral stenosis. The average age of onset of established atrial fibrillation in mitral stenosis in one study was 54 years.[1] The average age of onset of atrial fibrillation in coronary artery disease is considerably older.[2]

Dyspnea in mitral stenosis is related to elevated left atrial pressure and interstitial pulmonary edema. Frank congestive heart failure may be the immediate result of the onset of atrial fibrillation in patients with high-grade mitral stenosis. The cardiac output in tight mitral stenosis is reduced 20 to 25% by the loss of atrial contraction with the onset of atrial fibrillation.[3]

Conclusions

1. Atrial fibrillation in persons below the age of 60 years is commonly the result of mitral stenosis.
2. Dyspnea and frank congestive heart failure in mitral stenosis are often coincident with the onset of atrial fibrillation.
3. The onset of atrial fibrillation in mitral stenosis suggests mitral stenosis of considerable duration.

Case 2

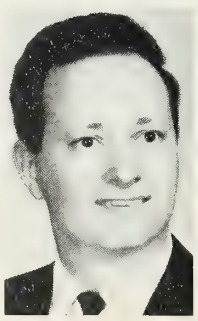
A 25-year-old man developed spontaneous atrial fibrillation. There was no history of rheumatic fever. Physical examination revealed a loud S1, loud pulmonic closure sound and a mid-diastolic rumble at the apex. No opening snap was heard. Cardiac catheterization revealed markedly elevated left atrial pressure with exercise. Cardiotomy revealed generalized cardiac muscle disease. Mitral stenosis was not present.

The patient's course over the next 52 months was punctuated by recurring congestive heart failure, pulmonary emboli, chronic atrial fibrillation which was refractory to cardioversion and finally sudden death.

Autopsy revealed marked diffuse interstitial cardiac fibrosis. The etiology of the cardiac disease could not be established.

Comment

Atrial fibrillation may be the initial manifestation of a cardiomyopathy.[4] Atrial fibrillation in a young person with cardiomegaly and no murmur is highly suspicious of cardiac muscle disease. Occasionally, ventricular gallops in cardiomyopathies are mistaken for the opening snap or mid-diastolic rumble of mitral stenosis. As in this case, cardiac surgery may rarely reveal the presence of cardiomyopathy when rheumatic heart disease has been the suspected diagnosis.[5] Atrial fibrillation may contribute to the congestive heart



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failure in cardiomyopathies. Cardioversion may improve cardiac output by 20%.[6] Failure to maintain sinus rhythm following cardioversion in cardiomyopathies is commonly related to left atrial size and the involvement of the atria by the underlying disease.

Conclusions

1. The diagnosis of a cardiomyopathy must be considered when atrial fibrillation occurs in young persons, especially in the absence of cardiac murmurs.
2. Although cardioversion may be useful when atrial fibrillation is contributing to serious congestive heart failure, it is often unsuccessful in advanced cardiomyopathy.

Case 3

A 53-year-old man developed an acute inferior myocardial infarction in January, 1970, which was complicated by papillary muscle dysfunction and congestive heart failure. One year later, he began having recurrent transient bouts of palpitations associated with dyspnea. Paroxysmal atrial fibrillation was documented in April, 1971, when he was hospitalized for congestive heart failure.

Over the next 29 months, bouts of congestive heart failure correlated with bouts of paroxysmal atrial fibrillation. The ventricular rate was notably difficult to control with digoxin during these episodes. Persistent atrial fibrillation has been present since September, 1973. Physical examination reveals cardiomegaly, grade 3/6 pansystolic apical murmur radiating to the left axilla and back, an apical S3 gallop and a lound pulmonic closure sound. He is presently doing well on digoxin, diuretics and salt restriction. His ventricular rate is 80-90 per minute.

Comment

Atrial fibrillation is a common manifestation of coronary artery disease. It occurs in 10% of patients with acute myocardial infarction where it is generally a transient arrhythmia.[7] Atrial fibrillation may be found as an incidental rhythm in patients with otherwise asymptomatic coronary artery disease. It occurs often late in the course of coronary artery disease in association with congestive heart failure. Factors contributing to the development of atrial fibrillation in coronary artery disease include ischemia of the sinus node and atrium, fibrosis of the atrium and severe enlargement of the left atrium resulting from papillary muscle dysfunction and mitral regurgitation.[8] The onset of atrial fibrillation was found to be the most common cause of symptoms and disability in patients with all forms of chronic mitral regurgitation including papillary muscle dysfunction.[9]

Conclusions

1. Atrial fibrillation may be asymptomatic in some patients with coronary artery disease.
2. Symptoms and disability in coronary artery disease often correlate with the onset of atrial fibrillation.

Case 4

A 53-year-old woman with known mitral stenosis and chronic atrial fibrillation developed a sudden right hemiparesis which cleared within 24 hours. She was placed on anticoagulants which were necessarily discontinued later because of massive hematuria. One week later she developed increasing difficulty walking and mental confusion. Physical examination revealed poor performance of fine movements bilaterally and truncal ataxia. Atrial fibrillation, mid-diastolic rumble and a left parasternal lift were notable findings related to mitral stenosis.

Cerebral arteriography revealed evidence of multiple bilateral emboli. The patient died two weeks later.

Comments

Systemic embolization may precede all other manifestations of mitral stenosis and is distinctly more common when atrial fibrillation is present. In one study, systemic embolism was seven times more frequent in atrial fibrillation than in sinus rhythm.[10] In the same study, systemic embolization generally occurred within the first year of onset of the atrial fibrillation and tended to recur. Anticoagulation significantly reduces the incidence of systemic embolism in atrial fibrillation.[10]

Cardioversion should be attempted when atrial fibrillation is found in association with mitral stenosis early in the course of the arrhythmia to decrease the possibility of systemic embolism. Quinidine is useful in preventing the recurrence of atrial fibrillation following cardioversion. Long-standing atrial fibrillation, as well as severe mitral stenosis, tend to limit the success of cardioversion.

Mitral valve surgery in mitral stenosis has been found by some authors to reduce the incidence of late systemic emboli even in the face of persistent atrial fibrillation.[11]

Conclusions

1. Atrial fibrillation increases the risk of systemic embolism in mitral stenosis.
2. The onset of atrial fibrillation in mitral stenosis presages early systemic embolization and is indication for prophylactic anticoagulants and cardioversion.

Case 5

A 52-year-old man developed increasing congestive heart failure over a 2-year period. He had had one bout of effort syncope several months prior to hospitalization. He gave a history of rheumatic fever in 1950. Physical examination revealed an irregular apical heart rate of 80 per minute. BP 100/60 mm Hg. There were moist rales at the left base and signs of a large right pleural effusion. The carotid upstroke was markedly delayed and the carotid pulses were barely palpable. A grade 2/6 harsh systolic ejection murmur was heard at the apex and base and radiated into the neck. There was an early diastolic blow at the left lower sternal border. There was no thrill. An opening snap was not heard.

Cardiac catheterization revealed severe aortic stenosis and severe mitral stenosis with calculated valve areas 0.5 cm^2 and 0.6 cm^2 respectively. The patient died immediately postoperative following replacement of both valves.

Comment

Atrial fibrillation is uncommon in isolated aortic stenosis.[12] Since the left ventricular pressures in aortic stenosis tend to diminish the auscultatory manifestations of mitral stenosis, atrial fibrillation may be the only clue suggesting associated mitral stenosis.

Atrial fibrillation is followed by marked deterioration in cardiac output in advanced aortic stenosis because of the loss of atrial contribution to left ventricular filling. Sudden death in severe aortic stenosis may be related to the onset of rapid atrial fibrillation.

Conclusions

1. Atrial fibrillation in aortic stenosis is a significant clue to coexistent mitral valve disease.
2. Atrial fibrillation seriously impairs left ventricular function in severe aortic stenosis.

Case 6

A 71-year-old woman was seen in March, 1971, with congestive heart failure, uncontrolled atrial fibrillation and a toxic nodular goiter. She had lost 30 pounds in the preceding 4 months. Physical examination revealed a multinodular goiter, prominent lid lag, smooth, warm skin, bounding carotid pulses and hyperactive deep tendon reflexes. BP 160/80 mm Hg. Apical heart rate 120 per minute. There was cardiomegaly, an apical pansystolic murmur, a third heart sound gallop and elevated jugular venous pressure.

EKG revealed atrial fibrillation and loss of R waves over the right precordial leads. RAI uptake 66% in 24 hours. Serum thyroxine 11.5 mcg/100 ml. (N=3-7)

In August, 1971, she was clinically euthyroid on propylthiouracil 300 mg orally daily. Atrial fibrillation, cardiomegaly and the pansystolic murmur persisted. The jugular venous pressure was normal and there was no gallop. The apical heart rate was 88 per minute on digoxin .25 mg orally daily.

Comment

Atrial fibrillation is nearly always present when congestive heart failure occurs in thyrotoxicosis and suggests underlying cardiac disease.[13] It occurs more often in thyrotoxicosis in older persons than in younger thyrotoxic patients. Atrial fibrillation with rapid ventricular rates difficult to control with digitalis should prompt investigation for associated thyrotoxicosis. Cardioversion should be attempted only after the patient has become euthyroid on therapy.

Conclusions

1. Atrial fibrillation in thyrotoxicosis is most often the result of underlying heart disease and generally occurs in older patients.
2. Control of the thyrotoxicosis leads to easier control of the atrial fibrillation and congestive heart failure.

Case 7

A 73-year-old woman was treated with a permanent pacemaker because of marked sinus bradycardia and near-syncopal episodes associated with the sick sinus syndrome. Following implantation of the permanent pacemaker atrial fibrillation occurred intermittently requiring digitalis therapy to control the ventricular rate.

Comment

Atrial fibrillation may occur in the sick sinus syndrome.[14] It is important to recognize atrial fibrillation as a part of the sick sinus syndrome

since therapy is primarily influenced by the occurrence of sudden episodes of severe cardiac slowing associated with syncope. Ultimate control of the atrial fibrillation in this syndrome can be safely accomplished with digitalis only after implantation of a permanent pacemaker. Cardioversion is contraindicated in atrial fibrillation when there is a chronic bradycardia or when episodic severe slowing is present as in the sick sinus syndrome.

Conclusions

1. Atrial fibrillation in the sick sinus syndrome is generally easily recognized when there is marked bradycardia or episodic ventricular slowing in the absence of digitalis therapy.
2. Permanent pacemaker implantation is the mainstay of therapy in this syndrome.

Discussion

Atrial fibrillation is generally an indication of underlying cardiac disease. Its onset often heralds clinical deterioration in otherwise stable cardiac disorders. This paper emphasizes the associaton of atrial fibrillation in its commonest clinical settings. The relationship of atrial fibrillation to left atrial pathophysiology and disease of the mitral valve is noteworthy. The adverse effects on cardiac output and the propensity for left atrial clot formation leading to systemic embolization are the most important consequences of atrial fibrillation.

On the basis of this brief review of the implications of atrial fibrillation, the following conclusions and recommendations are made:

1. Consider atrial fibrillation a sign or a symptom and search for an underlying cardiac disease.
2. Digitalis is the single most useful drug in controlling the ventricular rate in atrial fibrillation.
3. Cardioversion should be considered in mitral stenosis early in the course of atrial fibrillation.
4. Cardioversion may be useful in any case when atrial fibrillation is seriously impairing cardiac output.
5. Quinidine should be given following cardioversion to prevent the recurrence of atrial fibrillation. It has no place in the therapy of chronic persistent atrial fibrillation.
6. Anticoagulant therapy should be considered when atrial fibrillation occurs in mitral stenosis.
7. Anticoagulants may be useful in cardiomyopathies accompanied by atrial fibrillation.
8. Propranolol may be useful occasionally in slowing rapid ventricular rates in atrial fibrillation in thyrotoxicosis, especially in conjunction with digitalis.
9. Atrial fibrillation in thyrotoxicosis is best managed after restoring the euthyroid state.
10. Atrial fibrillation may be part of the sick sinus syndrome. Successful management includes an implanted permanent pacemaker plus digitalis. ◄

References

A complete bibliography for Clinical Implications of Atrial Fibrillation may be obtained by writing the Illinois Medical Journal, 55 E. Monroe St., Suite 3510, Chicago, 60603.

EKG

(Continued from page 141)

Answers: 1. C 2. C

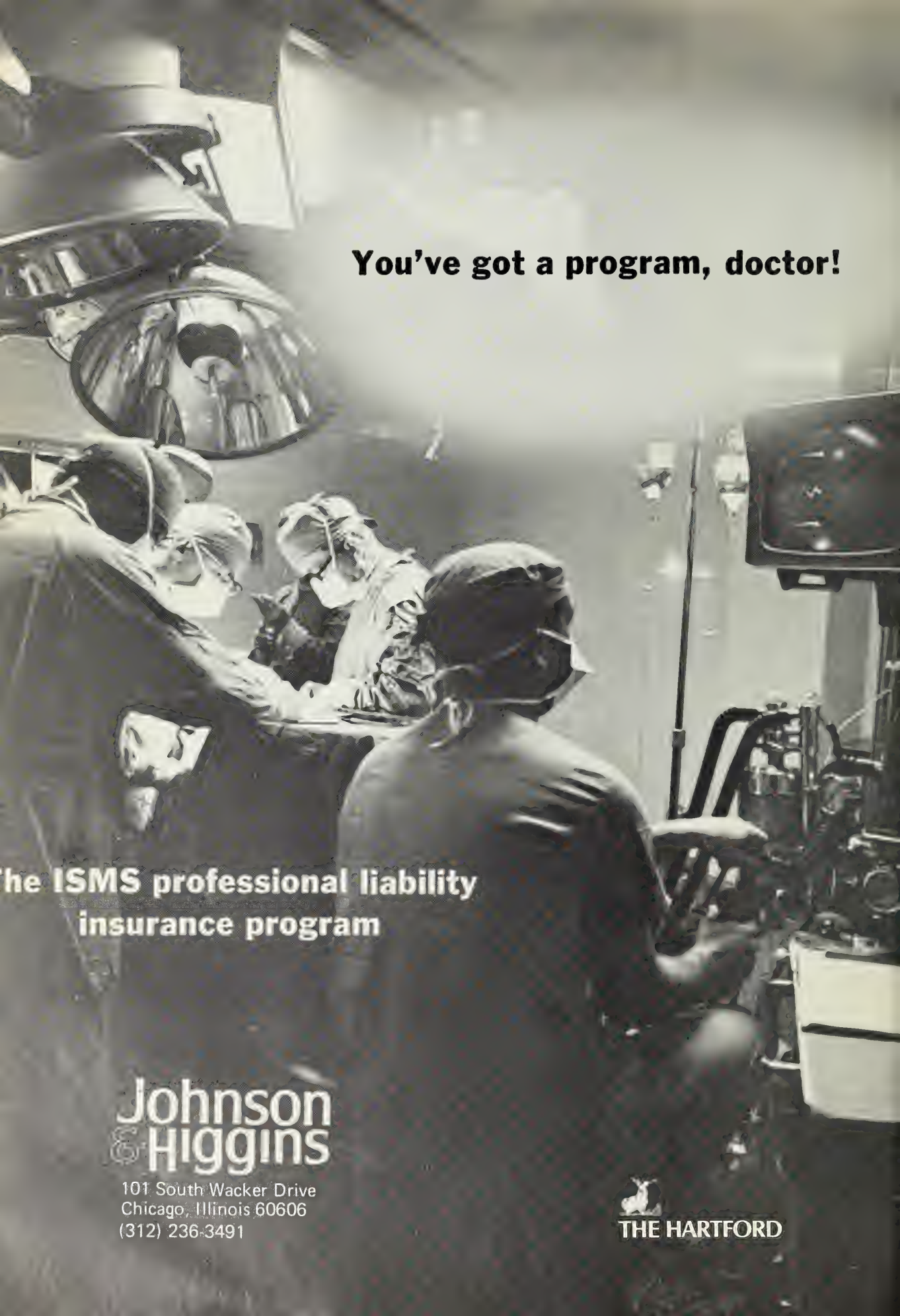
The Q-T interval represents the time required for depolarization and repolarization of the ventricles. It varies with age, sex, and cardiac rate. The upper limit of normal at cardiac rate of 70 or more is 0.42 seconds. On initial inspection of the tracing the Q-T interval should be less than 50% of the R-R interval. If it is longer, a table should be consulted for the corrected interval. The Q-T interval varies inversely with calcium level of the blood. Q-T interval is shortened with high calcium and prolonged with low calcium levels. The T wave remains essentially unchanged. The Q-T interval will usually be prolonged in hypoparathyroidism, uremia, after prolonged vomiting, or forced breathing. The patient had severe hyperventilation syndrome with transient hypocalcemia.

Viewbox

(Continued from page 146)

DIAGNOSIS: *Systemic lupus erythematosus*—The radiographic abnormality seen in this disease in the chest involves non-specific, poorly defined patchy densities usually at the lung bases and situated peripherally. These changes often are acute and probably represent small areas of pneumonitis which respond to steroid therapy. Pleural effusions are frequently bilateral as seen in our case, and are usually small but may be massive. The heart is usually involved and frequently associated with pericardial effusion.

The radiograph of the hip reveals sclerotic changes as well as flattening of the femoral head as a result of aseptic necrosis. Ischemic necrosis of bone has been reported with increasing frequency in lupus. This occurs either with or without the use of steroid therapy. This patient had a positive L.E. cell test as well as a positive renal biopsy.


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Doctor's News

PHYSICIANS WHO DISPENSE MEDICATION from their offices are reminded that they are subject to requirements in several laws. The Medical Practice Act specifically allows such dispensing. The Pharmacy Practice Act identifies the labeling requirements. The Controlled Substances Act indicates the inventories needed, additional labeling, and refill policies for dangerous drugs. The Hazardous Substances Act requires child-resistant containers in certain instances. And these Acts are supplemented by Federal laws.

Reports have been made to ISMS headquarters that some physicians are not complying with these Acts when dispensing medication from their offices. Thus, this reminder—since there is an implied threat of regulatory action, as necessary, in the report.

PHYSICIANS' MEDICARE FEE INDEX limits reimbursement to 17.9% above levels prevailing in fiscal year 1973. This new payment formula, now in effect, will save the government an estimated $26 million during this fiscal year out of a total Medicare Part B outlay of $3.2 billion, according to HEW Secretary Weinberger.

The AMA, which angrily debated this fee index, has charged that Congress intended local, rather than national indexes; that the limitation was not supposed to be on a procedure-by-procedure basis but an aggregate; and that HEW allowed insufficient time for discussion on the manner in which it has decided to draw up the index. The control will simply force more physicians to abandon the assignment method, AMA warned.

AVERAGE COST OF HEALTH CARE for a person 65 years of age or older in fiscal 1974 was nearly three times the health care costs of the average U.S. resident, according to the Social Security Administration. In the June issue of the "Social Security Bulletin," SSA reports that the older person's fiscal 1974 bill averaged $1,218. The national average for all persons was $420. Total personal health care expenditures for fiscal 1974 were estimated at $90.3 billion. This is 87 percent of the total national health expenditures which also include research, construction and administration.

BICENTENNIAL PROJECT to honor Dr. Benjamin Rush, the physician who signed the Declaration of Independence. Dr. Rush distinguished himself as a patriot, physician and humanitarian. He served as Physician General of the Continental Army, was the first professor of chemistry in America, and wrote the first American text on chemistry, founded the first medical clinic for the poor and was a founder of the College of Physicians of Philadelphia.

Dr. Rush championed the cause of the poor, the alcoholic and the criminal. He founded the first organization for the abolition of slavery and sponsored prison reform and the rehabilitation of criminals. As a tribute to him, the Pennsylvania Medical Society and other medical groups have adopted the restoration of the Rush house as their official Bicentennial project. It is appropriate that physicians from every state honor Dr. Benjamin Rush as the foundations of American medicine rest upon his pioneering efforts.

Doctors are asked to support the restoration of the Benjamin Rush house. Each gift of $1,000 or more will be recorded on a tablet in the restored House. Contributions should be sent to the Benjamin Rush House Committee, 111 North 49th Street, Philadelphia, Pennsylvania 19139.

RECENT ACTIVITY OF THE MEDICAL EXAMINING COMMITTEE of the Illinois Department of Registration and Education resulted in proposed rules being suggested to the Director of that Department. These include allowing chiropractors to utilize acupuncture (tacitly approving venipuncture by chiropractors in the same way); authorizing chiropractors to take PAP smears; expanding on those who may do ear piercing, by including barbers and beauty culturists.

Since many concerns are present, should these be promulgated, physicians are encouraged to contact the Department Director at 55 E. Jackson, 17th Floor, Chicago. In addition, ISMS would like to know your viewpoints. If you currently utilize acupuncture please drop a note to the *IMJ* so a mini-census or sample survey can be developed to assist in formulating responses and expert resource personnel.

PHYSICIANS IN THE NEWS—Two Illinois physicians, **John W. Keifer, M.D.**, and **Antonio John Carballo, M.D.**, were conferred the Degree of Fellowship of the American College of Nuclear Medicine. This is the highest honor the American College of Nuclear Medicine confers and is recognition of outstanding accomplishment and dedication in the field of nuclear medicine.

The National Multiple Sclerosis Society has awarded an 18-month research grant of $29,180 to the Rush Medical College to support the work of **Dr. Floyd A. Davis,** Associate Professor in the Department of Neurological Sciences. Dr. Davis will be studying the pharmacological improvement of impulse conduction in demyelinated nerves.

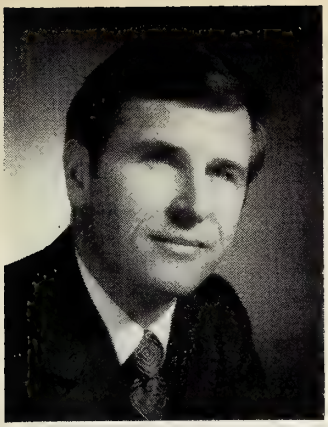
A bequest of $372,000 for the establishment of a scholarship fund at the University of Illinois College of Medicine in Chicago has was made from the estate of the late surgeon, **Sol H. Maizus, M.D.** Dr. Maizus came to this country as a penniless Russian immigrant in 1909 and worked his way through school until his graduation from medical school in 1922.

Dr. William L. Hall was honored at a public reception sponsored by the Bond County Medical Society for his 60 years of medical practice, from which he retired on June 15. Dr. Hall opened his medical practice in Greenville in 1917 and has practiced medicine there ever since except for a tour of duty with the Army Medical Corps during the first world war. The Bond County Medical Society, ISMS, and St. Louis University School of Medicine, Dr. Hall's alma mater, also expressed their appreciation of Dr. Hall's long service in the field of Medicine.

He has served as chief of staff at St. Joseph's Hospital, Highland and was chosen chief of surgery when Utlaut Memorial Hospital was opened. As well he holds membership in not only the local and state medical societies but also is a charter member of the Academy of General Practice, a charter member of the Illinois Surgical Society, and a member of the AMA.



Dr. William L. Hall of Greenville



President's Page

Things I Wish I Knew

To effect change and initiate new programs in medicine without asking how it affects the patient seems to be the order of the day. As I go about fulfilling the duties of president, it has become evident that there are a few things I need to know.

Things I wish I knew:

- Why people claim to "dislike" government control in other areas and still call for government control of medicine.
- Why we hear demands for greater concern for the individual and, at the same time, allow the "least personal" institution (government) of all to become more and more involved.
- Why many of those espousing "concern for the individual" use *group* statistics to justify their actions and programs.
- How we can observe government's mismanagement of HUD, railroads, the Indian Health Service and the postal service and still ask this organization to assume responsibility for cost control and quality care.
- Why the bureaucracy believes that it can manage medical care systems when it cannot even monitor FMG examination sessions.
- How much longer governmental deficit spending can persist.
- How we can remain calm when non-medical personnel place—in the name of quality—controls on the private sector and not on the government sector.
- Why so little credit or attention is given to individual experience, and why this experience and initiative is suppressed by "innovative" programs.
- How a person can be a true "expert" without personal experience.
- Why physicians are so eloquent during verbal exchanges in the hospital dressing room and so ineffective in efforts to educate the public concerning our common problems.
- Why hospitals and/or institutions seem to blindly accept the concept that bigger is better.
- How some hospital administrations can believe that their boards are complete without physician representation.
- Why fiscal agencies and some legislators attempt to control hospital costs after the fact, and refuse to recognize that as petroleum costs increase, so do hospital costs.
- Why educators cannot recognize the marked shortage of bedside RNs and the need to increase their ranks in order to provide more individual patient care.
- If, after obtaining a masters degree, a nurse ever touches a patient.
- Why some members of the news media consider themselves experts after writing one article—compiled only from other articles by other authors—on a medical topic.
- Why people accept the view that medicine is a "non-system" when, in reality, those expressing that opinion lack an understanding of the intricacies of the system's structure.
- How to impress upon our critics that—contrary to the theories of planners—disease does not strike only between 9 a.m. and 5 p.m., five days a week.
- Why a weekday emergency has to be reviewed within 24 hours, but a Friday night emergency can wait until Monday.
- How a weekend emergency admission can be less important to the patient or less urgent than a weekday admission.
- If I ever will feel less lonesome than I do at 2 a.m. in the emergency room with a patient who is in shock and suffering from multiple injuries.
- If I ever will feel more satisfied than I do when a patient walks from the hospital after a long and arduous recovery.
- How insurance agents are certain that a patient needs an X-ray and I am not.
- If the harassment which medicine is expressing at the present time may not actually present us with a tremendous opportunity to educate the general public and our critics about the true excellence of the majority of physicians . . . and the excellence of the majority of medical care received by the people of this country. ◄

J. M. Ingalls, M.D.

J. M. Ingalls, M.D.



Housestaff as Teachers

The "Housestaff News" is designed for interns and residents. News items and short articles of interest to housestaff will be considered for publication; materials should be sent to Michael Hughey, M.D., 711 Laurel Avenue, Wilmette, Ill. 60091.

By Linda Hughey, B.S./Chicago

The roles of housestaff officers are many and varied. Recently, much debate has centered on the roles of the housestaff officer as a physician and as an employee. One of the most important roles has received little attention: the role of the housestaff officer as a teacher. The words and actions of the housestaff physician are important sources of teaching for students, patients, support personnel, and attending physicians.

In a teaching institution, housestaff may have formally recognized teaching responsibiilties to medical students. Housestaff officers frequently assume the bulk of the actual teaching. As increasing numbers of hospitals acquire university affiliations, teaching responsibilities will extend to more and more housestaff officers. Enormous variation occurs already, however, in the time and effort extended towards teaching, even within the same program. Beset by many responsibilities, some resident preceptors leave their students to flounder while other equally busy residents manage to spend a great deal of time with their students. The latter practice will pay off in time. A housestaff officer who knows his students' capabilities can work with them as a team to lighten his own load. Furthermore, well-trained students will enhance patient care within the instituion and enhance the reputation of that institution after they graduate.

An equally important but often forgotten area of housestaff teaching responsibility involves the support personnel. Some housestaff officers seem to consider it beneath them to share with non-physician coworkers their knowledge of the patients' problems. But patient care depends on teamwork; if ancillary personnel understand why a patient is handled in a certain way they are less likely to make mistakes and can do much to effect patient compliance. Similarly, patient education is a key teaching responsibility of the housestaff officer. The extra time spent explaining in simple terms why a certain regimen must be followed will greatly reduce the time spent in detecting and correcting failure to follow instructions.

The final task of the housestaff officer is the most challenging . . . that of instructing attending physicians. In this day of geometrically increasing medical knowledge, housestaff officers can serve as important sources of recent advances. Where the wiser practicing physicians welcome suggestions and information, often more insecure physicians find it difficult to simultaneously play teacher and student.

The pitfalls of the housestaff teaching role may be averted by following the simple guidelines outlined below. Most of them are obvious but they are too often ignored and forgotten.

Do encourage questions from students, nurses, etc.

Do not, as do many housestaff officers, assume that a question is a challenge to your authority; becoming defensive will only reveal your own insecurity.

Do not ridicule questions. Students afraid to ask questions will make mistakes out of their ignorance.

Do not be afraid to admit you do not know an answer. Honesty gains respect. Lying invites contempt.

Do exemplify proper procedures by act as well as by word, and observers will imitate you.

Do not verbally advocate one procedure while practicing a short-cut, as those less knowledgeable than you will cut the same corner.

Do share the whole range of duties fairly with students; expect them to realize that medical practice involves both routine and challenging tasks.

Do not shove all "scutwork' onto students; they will perform poorly, and you will have to bear both the students resentment and the responsibility for their mistakes.

Do encourage active participation in patient care; students learn more quickly from doing than from watching.

Do not give students responsibility which they are technically, legally, or emotionally unequipped to handle, as you must bear the responsibility.

Do keep students alert with good-natured questioning. Mild stress increases learning.

Do not grill students. Increasing stress beyond a reasonable level decreases both learning and the quality of performance.

Do question atending physicians in a non-threatening manner; good ones will welcome your curiosity.

Do have high expectations and give students much encouragement.

Do verbalize your criticisms; students cannot improve if they are not aware of their weak points.

Do not condone mediocre work or give students false praise indicating satisfaction with their work. To praise with your voice and write a poor recommendation with your pen is grossly unfair and in no way helps the student.

Do make the learning experience two-way. Perhaps the most valuable lesson you can teach is that a good physician is willing to learn from anyone around him. Medical students, nurses, patients, and practicing physicians can learn much from housestaff officers and from one another. As a central hub about which the others rotate, the housestaff officer serves a vital teaching role.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Infections due to susceptible strains of the following gram-negative organisms: *H. influenzae, E. coli, P. mirabilis* and *N. gonorrhoeae;* and gram-positive organisms: streptococci (including *Streptococcus faecalis*), *D. pneumoniae* and non-penicillinase-producing staphylococci. Therapy may be instituted prior to obtaining results from bacteriological and susceptibility studies to determine causative organisms and susceptibility to amoxicillin.

Contraindications: In individuals with history of allergic reaction to penicillins.

WARNINGS: SERIOUS AND OCCASIONALLY FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS REPORTED IN PATIENTS ON PENICILLIN THERAPY. ALTHOUGH MORE FREQUENT FOLLOWING PARENTERAL THERAPY, ANAPHYLAXIS HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. MORE LIKELY IN INDIVIDUALS WITH HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. BEFORE THERAPY, INQUIRE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS OR OTHER ALLERGENS. IF ALLERGIC REACTION OCCURS, INSTITUTE APPROPRIATE THERAPY AND CONSIDER DISCONTINUANCE OF AMOXICILLIN. **SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE. ADMINISTER OXYGEN, INTRAVENOUS STEROIDS AND AIRWAY MANAGEMENT, INCLUDING INTUBATION, AS INDICATED.**

Usage in Pregnancy: Safety in pregnancy not established.

Precautions: As with any potent drug, assess renal, hepatic and hematopoietic function periodically during prolonged therapy. Keep in mind possibility of superinfections with mycotic or bacterial pathogens; if they occur, discontinue drug and/or institute appropriate therapy.

Adverse Reactions: As with other penicillins, untoward reactions will likely be essentially limited to sensitivity phenomena and more likely occur in individuals previously demonstrating penicillin hypersensitivity and those with history of allergy, asthma, hay fever or urticaria. Adverse reactions reported as associated with use of penicillins: *Gastrointestinal:* Nausea, vomiting, diarrhea. *Hypersensitivity Reactions:* Erythematous maculopapular rashes, urticaria. *NOTE:* Urticaria, other skin rashes and serum sickness-like reactions may be controlled with antihistamines and, if necessary, systemic corticosteroids. Discontinue amoxicillin unless condition is believed to be life-threatening and amenable only to amoxicillin therapy. *Liver:* Moderate rise in SGOT noted, but significance unknown. *Hemic and Lymphatic Systems:* Anemia, thrombocytopenia, thrombocytopenic purpura, eosinophilia, leukopenia, agranulocytosis. All are usually reversible on discontinuation of therapy and believed to be hypersensitivity phenomena.

Dosage: *Ear, nose, throat, genitourinary tract, skin and soft tissue infections*—Adults: 250 mg every 8 hours. Children: 20 mg/kg/day in divided doses every 8 hours; under 6 kg, 0.5 ml of Pediatric Drops every 8 hours; 6-8 kg, 1 ml of Pediatric Drops every 8 hours. *Lower respiratory tract infections and severe infections or those caused by less susceptible organisms*—Adults: 500 mg every 8 hours. Children: 40 mg/kg/day in divided doses every 8 hours; under 6 kg, 1 ml of Pediatric Drops every 8 hours; 6-8 kg, 2 ml of Pediatric Drops every 8 hours. *Gonorrhea* (acute uncomplicated anogenital and urethral infections)—Males and females: 3 grams as a single oral dose. *NOTE:* Children weighing more than 8 kg should receive appropriate dose of oral suspension 125 mg or 250 mg/5 ml. Children weighing 20 kg or more should be dosed according to adult recommendations.

Note: In gonorrhea with suspected lesion of syphilis, perform dark-field examinations before amoxicillin therapy and monthly serological tests for at least four months. In chronic urinary tract infections, frequent bacteriological and clinical appraisals are necessary. Smaller than recommended doses should not be used. In stubborn infections, several weeks' therapy may be required. Except for gonorrhea, continue treatment for a minimum of 48-72 hours after patient is asymptomatic or bacterial eradication is evidenced. Treat hemolytic streptococcal infections for at least 10 days to prevent acute rheumatic fever or glomerulonephritis.

Supplied: Amoxicillin as the trihydrate: Capsules, 250 mg and 500 mg; oral suspension, 125 mg/5 ml and 250 mg/5 ml; pediatric drops, 50 mg/ml.



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Personal Proficiency Testing

As reported in this Journal and in "Action Report," the ISMS Board of Trustees has encouraged voluntary participation in proficiency testing by physicians conducting laboratory services in their private offices. Proficiency testing has been required of private, commercial laboratories and hospital laboratories for some time. This may be required of private physicians' offices. Perhaps any proposed requirement might be eliminated, or at least postponed, if physicians voluntarily participate.

At this time, there are two approved testing services in Illinois. You can write to either or both and ask for information regarding services provided, costs, and availability.

The first of these has a specific program for physician office laboratories called PEP—Proficiency Evaluation Program, and costs $139 per year. This is available from the College of American Pathologists, 7400 N. Skokie Blvd., Skokie, 60076. Phone (312) 677-3500. Director is Sherry Janek.

The second program is that of the American Association of Bioanalysts, Proficiency Testing Service, 105 West Elizabeth Street, Suite 107, Brownsville, Texas 78520. Phone (512) 546-5315. The basic program costs $135 per year. Director is Nickolas T. Serafy.

Several states recently enacted laws requiring that physicians itemize charges for laboratory services provided patients by outside laboratories, when the charge is part of the bill for professional services. A statutory requirement for this has been deemed unnecessary by the Laboratory Services Committee, which opinion was endorsed by the Board of Trustees. The Judicial Council of the AMA "Opinions and Reports" addresses this adequately, and reproduced here are those items applicable in this matter.

"Nothing in the Principles of Medical Ethics proscribes the submission of an itemized bill by a physician to his own patient for medical service he actually rendered to the patient."

"1. The practice of pathology is an integral part of the practice of medicine.

2. All physicians should bill their patients directly, and

3. In exceptional cases, when it is not possible for the laboratory bill to be sent directly to the patient, the referring physician's bill to the patient should indicate the charges for laboratory services, including the name of the physician director of the laboratory, as well as the charges for his own professional services."

James E. Habegger, M.D., *Chairman*
ISMS Medical Legal Council

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surgical grand rounds

Edited By JOHN M. BEAL, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of October 9, 1973.

Spontaneous Urinary Extravasation

Dr. Ronald Sadlowski: A 75-year-old white woman was awakened at 2:00 a.m. the morning of admission by severe sharp stabbing pain in the left upper quadrant of her abdomen. The pain was constant, unaffected by change in position or ingestion of aspirin. A history of urinary frequency, dysuria or trauma was absent. She presented herself at the Passavant Emergency Room. Past medical history included a left ureteral calculus thirty years earlier. She had a myocardial infarction in 1970, following which she had been taking Isordil.

Physical examination revealed an elderly white woman in acute discomfort who complained of left upper quadrant abdominal pain. Temperature was 99° F., pulse 104 and blood pressure was 190/100. Significantly physical findings were related to the abdomen where there was marked tenderness and guarding in the left upper quadrant. Bowel sounds were normal. Masses or organomegaly were not detected.

Laboratory data: hemoglobin 14.3, hematocrit 42 per cent and white blood cell count 10,000, with 90 per cent polymorphonuclear leukocytes. Serum electrolytes, blood urea nitrogen, calcium phosphorus and uric acid were within normal limits. Urinalysis revealed 25-30 red cells per high power field with an occasional white cell. Urine culture did not yield any growth. After admission, an intravenous pyelogram was obtained.

Dr. Leonid Calenoff: The plain film of the abdomen outlined poorly the left kidney shadow and failed to demonstrate radio-opaque calculi. Extravasation of contrast material in the area of the left renal hilus was demonstrated on the intravenous urogram done on admission (Fig. 1). The contrast material obscured the ureteropelvic junction and the calyceal system and extended beneath the renal capsule at the lower pole of the kidney. The left ureter was very faintly opacified.

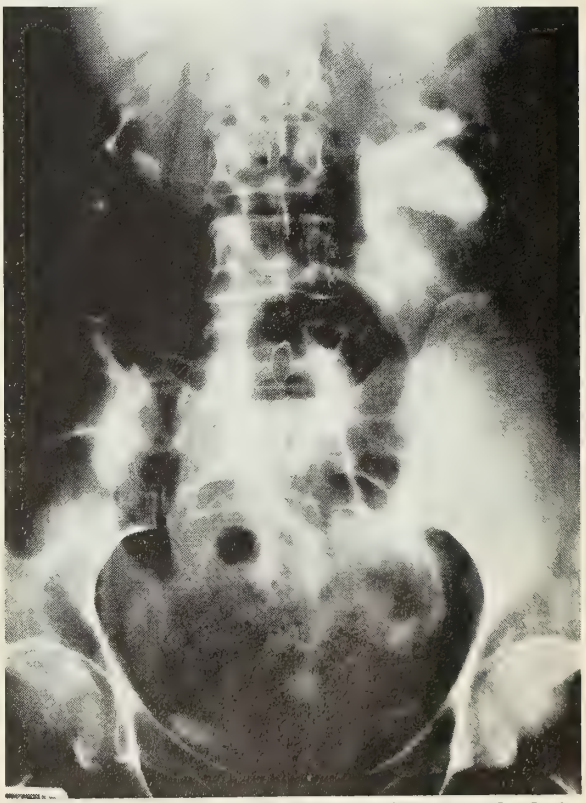


Figure 1. Intravenous urogram at the time of admission demonstrates extravasation of contrast material around the left renal pelvis.

Dr. Ronald Sadlowski: Several attempts were made to pass the stone basket but they were unsuccessful. A left ureteral catheter was finally inserted into the left ureter and left in place. The patient had a low grade temperature elevation of approximately 100° F. There was resolution of her discomfort and four days later contrast agent was injected through this indwelling catheter.

Dr. Leonid Calenoff: Extravasation of contrast material around the renal hilus was also demonstrated on the retrograde examination performed 2 days after the intravenous urogram. A small filling defect was noted in the left lower ureter on a few of the retrograde films. This was suggestive of a non-opaque calculus. No extravasation was demonstrated on the second retrograde done 4 days later (Fig. 2). The left ureter, however, remained dilated and tapered at the distal end. Again, a 3 mm. filling defect was seen in the distal ureter.

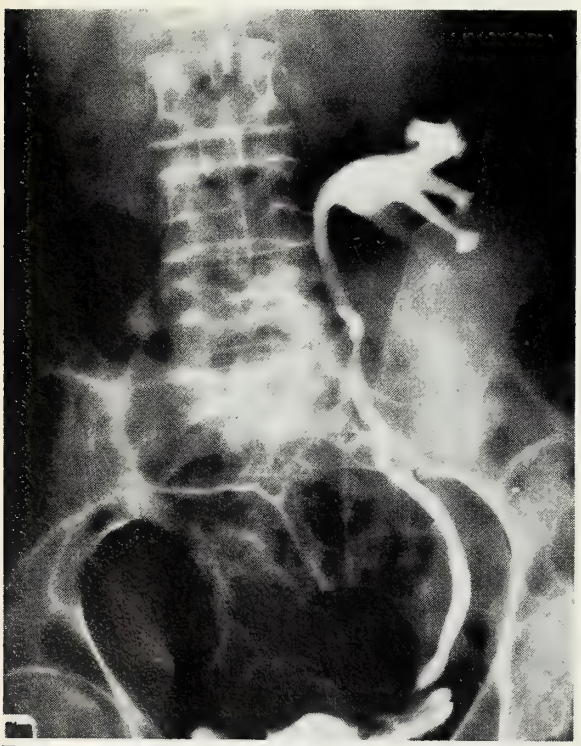


Figure 2. Left retrograde examination, performed 5 days after the original examination, shows no evidence of extravasation and a small, 3mm., radiolucent defect in the lower ureter suggestive of a calculus.

Dr. Ronald Sadlowski: The catheter was removed and the patient was observed. She continued to improve and five days later a drip infusion pyelogram was obtained.

Dr. Leonid Calenoff: A drip infusion urogram, performed 4 days after the second retrograde, showed no extravasation but a persistent dilatation of the left ureter. The special effort to demonstrate a calculus in the dilated, contrast filled left ureter was not rewarding.

Dr. Ronald Sadlowski: A review of the literature reveals early controversy concerning the mechanism which produces the radiographic and clinical findings of "spontaneous" urinary extravasation. In 1938, Narath reported the first case of extravasation of urine about the renal pelvis and upper ureter as visualized by intravenous pyelography. A calculus was not identified at the time of surgical exploration and subsequent nephrectomy failed to reveal evidence of pelvic or ureteral rupture. Subsequently numerous investigators have found this is secondary to rupture of the calyceal fornix in most instances, due to an acute increase in intrarenal pelvic pressure. This is followed by an extravasation into the perihilar fatty tissue within Gerota's fascia. The condition has been designated as pyelo-sinus extravasation and has occurred in the presence of ureteral calculi, ureteral ligature posthysterectomy, carcinoma and by prolonged acute abdominal compression during intravenous pyelography. The common factor in all reported cases has been acute ureteral obstruction.

Olson, in 1948, found 100 cases of urinary backflow with abdominal compression during routine urography with an incidence of 2.5 per cent in all the cases he examined. This rate has been corroborated by several other authors. Of these, 89% were of the pyelo-sinus type. Olson noted that increased renal pelvic pressure is essential for the production of backflow, either by purposeful ureteral compression from 20-40 minutes, or by obstruction of the urinary outflow. He then presented six cases of renal colic in four of which he demonstrated calculi in the pelvic ureter. He postulated that pyelo-sinus backflow may be a necessary physiologic compensatory mechanism in renal colic to relieve the increase in renal pelvic pressure. His conclusions are further affirmed by Fine and Vermooten in 1960 who presented three cases of spontaneous extravasation, two having calculi.

Forsyth and associates in 1958 reported seven cases, four with stones, one with peripelvic fibrosis and obstruction, one with ureteral ligation at the time of hysterectomy, and one with a ureteral kink after removal of a cervical stump. Schwartz and associates in 1966 reviewed 256 IVP's taken without external compression over a ten year period during or immediately after acute colic and found 16 cases of extravasation, only one of which required operation and that for drainage

of a perirenal urinoma.

Hinman in 1961 made one of the best pathophysiological correlations while evaluating five cases of extravasation, four with calculi, and one with a ligated ureter. He postulated that the sudden increase in pelvic pressure leads to penetration of the fornices by urine, which then could take one of three paths. One is by absorption by the lymphatics or pyelolymphatic backflow; a second is rupture into the venules or pyelovenous backflow, and third is dissection into the renal sinus called pyelo-sinus or peripelvic extravasation. He thought that the last was by far the most common. At surgical exploration of the patient with the ligated ureter, he noted Pyridium which the patient had been taking, to be in the fluid around the renal pelvis in such high concentration that it was felt to come directly from the renal pelvis and not from ruptured lymphatics. Furthermore, by injecting India ink into cadaver renal pelves under pressure, he demonstrated that a potential route exists for the spread of substance between the fornix and the peripelvic region. Two of his other cases were explored and rents were not found in the pelvis or the ureter.

Others have shown that the backflow phenomenon is probably initiated by sudden increase in intrapelvic pressure but that once backflow is established, less pressure is required to maintain it. The urinary extravasation is eventually absorbed by the perirenal lymphatics unless the pelvic pressure is sustained in which case further dissection occurs into the perihilar and periureteral tissue within Gerota's fascia. Distingiushing between pyelo-sinus backflow and actual pelvic or ureteral rupture, which has also been reported, is important since the mode of treatment is usually different. In backflow, the main diagnostic point is the presence of extravasation around the calyces is almost always identifiable and not present with ruptures. In ruptures, the contrast laden urine will spread along side the pelvis before the pelvis is even filled. If doubt still exists, the retrograde pyelogram may solve the problem since in rupture, the contrast media will spread peripherally from the rupture site and not around the calyces.

In summary, it is important to realize that there is a spectrum of presentation and degrees of serious risk to the patient. Simple backflow extravasation, the most common clinical type, should have treatment directed towards primary relief of the obstruction. With evidence of infected urine or instrumentation, coverage with appropriate antibiotics is indicated. Open surgical drainage is not usually indicated unless obstruction persists, infection develops, or pelvic or ureteral rupture identified as perinephric abscesses have been noted to occur under these circumstances. Clinically, most patients with pyelosinus backflow remain afebrile and have gradual relief of their pain without further therapy than relieving the obstruction. On repeat urography, no extravasation can usually be seen.

Dr. John T. Grayhack: As I thought about this patient and what we learned from her, it seems to me that two important aspects of patient care deserve emphasis; the first is the importance of an accurate diagnosis and the second is the importance of knowledge of the natural history of the disease process which is present. With regard to accurate diagnosis, this patient exemplifies the necessity for a urinalysis in someone with an acute abdomen. This patient had muscle guarding, tenderness, and rebound tenderness, signs indicating an acute abdominal inflammatory process. Admission was arranged by the surgical service with the thought that she probably would require abdominal exploration to determine the cause and treat an intraperitoneal inflammatory process. Fortunately, the red cells in her urine were discovered and led to the proper tests to establish the diagnosis.

It is easy to overlook the urinalysis in the helter-skelter rush to get the patient with an apparent acute abdomen to the operating room, but mistakes are made when this is done. This elderly woman may well have been spared a long, complicated, life threatening course by discovery and recognition of the importance of the abnormal urinalysis. Diagnostic accuracy was also important in assessing the large filling defect which was apparent in the lower ureter. Initially this was interpreted as an obstructing non-opaque stone. However, the negative filling defect, whether it was a blood clot, mucous, or an air bubble, disappeared on tilting and turning the patient, and what seemed to be a large stone almost certainly requiring an ureteral lithotomy was no longer present on repeated study.

This patient also emphasizes the importance of knowledge regarding the mechanism and natural history of a pathological finding. The extravasation which was seen in this patient is a pathophysiologic response to uerteral obstruction; it actually is a mechanism by which the kidney is protected. Ordinarily upper urinary tract extravasation of this type does not cause the patient a serious problem, in contrast to extravasation of the urine associated with a ruptured bladder. Recognition of these facts permitted election of a course of observation in this patient after the

obstruction was relieved.

Dr. John Beal: Dr. Grayhack, several questions. What was the cause of this obstruction that she had? Why did she have it?

Dr. John T. Grayhack: Well, we don't know for certain. It seems highly probable that she had a small calculus. The large filling defect probably resulted from mucous and other accumulated materials which were extruded during the attempted manipulation.

Dr. John Beal: What sort of pressures are generated in the urinary system with obstruction?

Dr. John T. Grayhack: The ureter can generate pressures of 50 to 100/cm of water with peristalsis. Ordinarily you would expect that when the pressure in the collecting system equals filtration pressure, formation of urine would stop; if that were the case, prompt impairment of blood supply would probably result in a small contracted kidney. However, as the pressure rises in the renal pelvis, pyelovenous and pyelo-lymphatic absorption, as well as urinary extravasation, act as safety valves to relieve the pressure. If you measured the pressure in the pelvis at the time there was extravasation, it would probably approximate venous pressure. ◄

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1. Narath, P. A.: "Extrarenal extravasation observed in course of intravenous urography." *J. Urol.*, 39:65, 1938.
2. Schwartz, A., Caine, M., Hermann, G. and Bittermann, W.: "Spontaneous renal extravasation during intravenous urography." *Amer. J. Roengen.*, 98:27, 1966.
3. Hinman, F., Jr.: "Peripelvic extravasation during intravenous urography; Evidence for an additional route for backflow after ureteral obstruction." *J. Urol.*, 85: 385, 1961.

On Insulin

Thirty-eight patients in diabetic coma from four different centers were treated with a continuous low-dose intravenous infusion of insulin at an average dose of 7·2 IU/hr. All patients recovered rapidly except for one profoundly shocked patient who died. The mean fall in plasma glucose was 58% four hours after the start of the insulin. Blood ketone bodies and plasma free fatty acids showed a similar response. There was no significant difference in plasma glucose response according to severity of acidosis or previous treatment with insulin. Hypokalemia was uncommon. In the treatment of diabetic coma this technique has proved simple, safe, and effective. (M. McB. Page, *et al*: "Treatment of Diabetic Coma with Continuous Low-dose Infusion of Insulin." *Brit. Med. Jl.* (June 29) 1974, pgs. 687-690).

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Bicentennial Celebration



Dr. Benjamin Rush (center) insists that his reform petition calling for improvement in the practices of the Continental Army's Hospital Service be heard by a full Congressional Committee. His close friends John Adams (left) and Congressman John Witherspoon of New Jersey (right) urge Rush to delay the petition, pointing out that General Washington has troubles enough of his own—he's at Valley Forge in the coldest winter in ten years. Rush insists that his petition will save lives.

"Physician to American Independence—Act II," an original drama portraying events in the life of Dr. Benjamin Rush, will be performed this summer at historic Christ Church in Philadelphia as a contribution to the Bicentennial observance.

The play's sponsor, pharmaceutical manufacturer Merck Sharp & Dohme of West Point, Pa., is continuing its tribute to Dr. Rush with a new play this year centering around the Congressional hearing called to air the dispute Rush raised about medical treatment of sick and wounded Colonial soldiers during the Revolutionary War.

Performances will be behind Christ Church, 2nd and Market Streets, Philadelphia, at 2 p.m. and 4 p.m. each Saturday and Sunday from June 14 through August 31. Admission is free.

The play has been authored by Charles Fuller, a Black playwright from Philadelphia now living in New York City.

Principal characters portrayed in the short play are Rush; John Adams; Benjamin Franklin; Congressman John Witherspoon of New Jersey; and Dr. William Shippen, Director General of the Medical Department of the Continental Army. Rush, the Philadelphia physician and fiery patriot who signed the Declaration of Independence, served under Shippen as Physician-General of the Middle Department of the Continental Army.

"He was anti-slavery, and he widely proclaimed the rights and dignity of women. He championed the educational rights of minorities, and his call for humane treatment of the mentally ill brought him the title of 'Father of American Psychiatry'. He was one of the few physicians to remain in Philadelphia during the horrendous Yellow Fever epidemic of 1793. While his method of treatment of the thousands stricken with Yellow Fever has been questioned, his dedication has not. He became Philadelphia's physician to the Black, the poor, and the disadvantaged . . . while authoring the first U.S. chemistry textbook and serving on the faculty at the University of Pennsylvania Medical School."

Ozone Recommendations

A proposal to develop a public education program on the health effects of ozone was made at a science writers' press briefing conducted by the Chicago Lung Association.

Presenting the proposal was Dr. Bertram W. Carnow, director of the Environmental Health Resource Center and medical director of Chicago Lung Association, who prepared a special study on the "Health Effects and Recommended Alert and Warning System for Ozone" for the Illinois Institute for Environmental Quality, an arm of the Illinois Environmental Protection Agency. He stated that the study had been undertaken last year to settle the public and governmenal confusion which arose when a yellow alert was called for ozone.

"Our purpose was to present a study which would more properly define the health risks of the normal and high-risk segments of the population to various levels of ozone exposure," Dr. Carnow said. He explained that ozone is a strong oxidizing agent found in our atmosphere which is largely formed by industrial and automotive activities and closely related to emissions of hydrocarbons and nitrogen oxides. Ozone is known to cause irritation of the nose, throat and lining of the respiratory system and also decrease breathing efficiency.

Other recommendations for further research are:

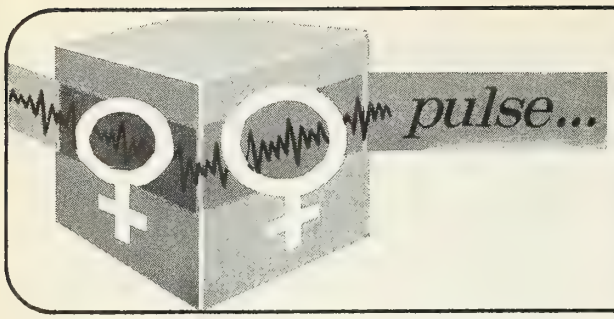
that present ozone monitoring actiivties be continued, though more rural monitoring stations should be added to determine the impact of weather on the formation and dispersal patterns of ozone,

that more closely designed epidemiological studies should be conducted on the health effects of ozone,

that experiments on the long-term, low-dose exposure to ozone be held to determine its carcinogenicity and behavior changing effects,

that its synergistic effects with other pollutants such as sulfur dioxide, nitrogen dioxides and heavy metals be studied, and

that an investigation be made to determine which people are more susceptible to ozone in order to more accurately identify the size of the population at high risk to ozone.



pulse... of the doctor's wife

Mrs. Harold Keegan, Editor

July 8, 1975

SUMMER GREETINGS!

In the enthusiastic glow which one has on returning from a pleasant vacation trip—with numerous medical friends on the INTRAV-ISMS trip to Ireland, Holland, and England—I want to share some thoughts which have occupied my mind a great deal lately.

Not only here in our best-ever U.S.A., but wherever we went, we found problems, of course, but we found people, for the most part, coping with their problems in a spirit of cheerful determination. Inflation, inadequate energy supplies, over-population, safety and security difficulties and diseases don't disappear just because a person is cheerful or finds good instead of evil wherever possible. Yet each of us, living his own life, wants it to be happy. To contribute to this and maybe to help solve the problems too, it is more constructive to be a GOODFINDER rather than a fault finder.

However heavy our burdens, we also have blessings. It makes life a lot more worth living if we increase our awareness of our blessings and, since none were guaranteed, express our gratitude for them.

Internationally, in the spirit of sharing experiences and developments in medicine, our physicians met in each country in several seminars led by outstanding specialists in various fields. Dr. George Callahan of ISMS, presided at the meetings. It was widely agreed that the sessions were outstanding in quality and our doctors felt they were genuinely worthwhile.

Together, we and our friends absorbed as much of the lore and geography of each city and country as we felt inclined to, or could, in the time available. We knew we could not "do it all," but we enjoyed what we did and we had ample opportunity for GOOD FINDING and for COUNTING OUR BLESSINGS.

With all best wishes, in the spirit of
GOOD FINDING!

Mrs. Eugene Vickery, President
Illinois State Medical Society Auxiliary

COUNT YOUR BLESSINGS!

DATES TO NOTE:

Sept. 24	— Fall Board Mtg. Ramada Inn Forum 30, Springfield, Ill. 1:30 p.m.—County Presidents Welcome
Sept. 25	— Patchwork Conference on Family and Community Health Ramada Inn Forum 30, Springfield, Ill.
Oct. 12-15	— AMA Aux. Conference Drake Hotel, Chicago, Ill.
Oct.	— District 1A Meeting (date and place to be announced)
Oct. 28	— District IV Mtg. Soangetaha C.C., Galesburg, Ill.
Nov. 6	— District IX-X Mtg. Belleville, Illinois
Nov. 11	— District III Mtg. Chicago, Illinois
Nov. 12	— ISMS & ISMS Aux. Conference on "Values" LaSalle Hotel, Chicago, Illinois

Atlantic City Convention

The AMA Aux. Conference was held in Atlantic City, June 15-18, 1975. Mrs. Howard Liljestrand presided at the meeting, at which 800 registered.

Mrs. Liljestrand presented four recommendations from the Board of Directors. They were:

1. Honorary membership for Mrs. E. R. W. Fox, 1974-1975 finance Chairman. An affirmative vote was received.
2. Bylaws revisions approved with some amendments.
3. A dues raise of $6.00/member was recommended—much discussion resulted and a $3.00/member increase was approved. Collections will not begin until July 1, 1976.
4. A change in the Auxiliary seal was presented—discussion followed, and a motion was presented to postpone any change until designs can be submitted by Aux. members with the stipulation that they be in a rectangular format as is the president's seal.

Illinois received much recognition this year for AMA-ERF and membership. The North Central Region (which includes Ill.) contributed the most dollars, Illinois made the largest state contribution ($150,949.89), the largest state contribution per capita ($55.50), and also received county achievement award for St. Clair County.

An Award was received for the greatest percentage of member increase for members-at-large and for the formation of 2 new counties. (Lee & Ogle) At the close of the convention Mrs. Erle E. Wilkinson was installed as 1975-1976 President. In her inaugural address she stressed "our organization law be a vital force and that we have the potential to improve health and health care. To do this we must become involved, both individually and as a group."

All in all a very interesting convention.

Four Attend Rape Conference

Four members of the Illinois State Medical Auxiliary attended as delegates the First National Conference to Combat Rape held in Indianapolis, Indiana, on May 18, 19, 20. The seminar was sponsored by the City of Indianapolis and the Indianapolis Women United Against Rape. The entire project was started two years ago by Margaret Moore Post, a well-known writer for an Indianapolis newspaper.

Those attending from the Illinois State Medical Auxiliary were Mrs. Edward Szewczyk, Vice-President, Belleville, Illinois, Mrs. H. Frank Holman, 9th & 10th District Councilor, Belleville, Illinois; Mrs. Frank Torrey, Chairman Family Health, Pekin, Illinois; and Mrs. Paul Wochos, Safety Chairman, Palatine, Illinois.

The program included visits to the hospitals, police departments, courts, and the Indiana Statehouse to view all aspects of handling rape situations and victims. Speakers included Dr. Morton Bard, father of the first Crime Intervention program in the New York City Police Department, and Dr. Carolyn Hursch, a consultant and authority on research on the victim and the rapist. Many city, county, and state officials also participated in the program.

ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
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Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

September, 1975

Basic Science

STATE & NATIONAL BOARD REVIEW COURSE, BASIC
For: GPs. 6½ day-Course. Sept. 28-Oct. 4, Chgo. **CME Credit:** 58 hrs. AMA Cat. 1. **Fee:** $225. **Reg. Limit:** 105. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

Cancer

THIRD ANNUAL CHICAGO SYMPOSIUM—NEOPLASM IMMUNITY: MECHANISMS
For: Oncologists, Surgeons, Internists, Hematologists. Two-day conference, Sept. 11-12, Blackstone Hotel, Chicago. **Credit:** 10 hrs. AMA Category 2. **Sponsor, contact:** Ray G. Crispen, M.D., Institute/TB Research, U/Illinois, 904 W. Adams, Chicago 60607.

Cardiovascular Disease

SPECIALTY REVIEW COURSE IN CARDIOVASCULAR DISEASE
For: Board certified or eligible applicants. 5-day Course. Sept. 22-26. Chgo. **CME Credit:** 40 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

Diabetes Mellitus

SECOND SYMPOSIUM ON DIABETES MELLITUS
For: Allied health professionals. **Symposium and Workshop.** Sept. 9 and 10, Playboy Towers Hotel, Chicago. **Fee:** $25 - 2 days; $15 - 1 day. **Reg. Deadline:** Sept. 5. **Sponsor, contact:** American Diabetes Assoc., 620 North Michigan Ave., Chicago, Ill. 60611, Nike Bradley, Ex. Dir.

Endocrinology

SPECIALTY REVIEW COURSE IN ENDOCRINOLOGY
For: Board certified or eligible applicants. 5-day Course. Sept. 8-12. Chgo. **CME Credit:** 40 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

Family Therapy

TWO YEAR TRAINING PROGRAM IN FAMILY THERAPY
For: Psychiatrists; Mental Health Professionals. Sept.-June. Meets once weekly. Chgo. **Sponsor, contact:** The Family Institute of Chicago, 10 E. Huron St., Chicago, 60611. Att'n: Percy Weber.

Gastroenterology

SPECIALTY REVIEW COURSE IN GASTROENTEROLOGY
For: Board certified or eligible applicants. 5-day Course. Sept. 22-26. Chgo. **CME Credit:** 40 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

General Medicine

FLUIDS AND ELECTROLYTE MANAGEMENT
For: GP, IM, FP, Surg. 5-day Course. Sept. 22-26. Chgo. **CME Credit:** 35 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 50. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

Hospital Administration

ORGANIZING FOR ACCOUNTABILITY: WHAT AN INDIVIDUAL HOSPITAL CAN DO
For: Hospital Administrators and Medical Directors. Two-Day Seminar. Sept. 22-23, Sheraton Chicago Hotel. **CME Credit:** 14 hrs. **Fee:** $200 for ACHA; $250 for non-affiliates. **Sponsor, Contact:** American College of Hospital Administrators, 840 Lake Shore Drive, Chicago 60611. Att'n: William J. Ranieri.

LABOR RELATIONS IN THE HOSPITAL SETTING: THE ADMINISTRATOR'S ROLE
For: Hospital and Health Care Executives. Two-Day Seminar. Sept. 10 & 11. Sheraton Oakbrook Hotel, Oakbrook, Ill. **Speakers:** Faculty from Melnick, McKeown, Mickus, Inc. **CME Credit:** 12 hrs. **Fee:** $200 ACHA; $250. Non-affiliates. **Reg. Limit:** 50. **Sponsor, contact:** American College of Hospital Administrators, 840 Lake Shore Drive, Chicago 60611. Att'n: William J. Ranieri.

Medical Audit

MEDICAL AUDIT PROCEDURE SEMINAR/WORKSHOP
For: Medical Records Staff and MDs. 3-day Seminar/Workshop. Sept. 3-5. Chgo. **CME Credit:** 14 hrs. AMA Cat. 1; 16 hrs. AMRA. **Fee:** 150. **Reg. Limit:** 50; **Reg. Deadline:** Aug. 27. **Sponsor, contact:** Joint Comm. on Accreditation of Hospitals, 875 N. Michigan, Chicago, 60611. Att'n: Laurie Kidd.

MEDICAL AUDIT TEAM SEMINAR (ADVANCED)
For: Medical Records Staff and MDs. 3-Day Seminar. Sept. 17-19. Chgo. **CME Credit:** 14 hrs. AMA Cat. 1; AMRA. **Fee:** $150. **Reg. Limit:** 50; **Reg. Deadline:** 1 week prior. **Sponsor, contact:** Joint Comm. on Accreditation of Hospitals, 875 N. Michigan, Chicago 60611. Att'n: Laurie Kidd.

Medical Oncology

SPECIALTY REVIEW COURSE IN MEDICAL ONCOLOGY
For: Board certified or eligible applicants. 5-day Course. Sept. 8-12. Chgo. **CME Credit:** 40 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

Medicine

HEMATOLOGIC MALIGNANCIES
For: MDs; Nurses. Lecture. Sept. 10. Chgo. **CME Credit:** 1 hr. AMA Cat. 1. **Fee:** None. **Co-Sponsors:** Martha Washington Hospital and American Cancer Society. **Contact:** Martha Washington Hospital, 4055 N. Western Ave., Chicago, 60618. Att'n: Fernando Lopez-Fernandez, MD.

DERMATOLOGY IN FAMILY PRACTICE
For: All physicians. Visiting Lecturer: A. Schroeter, M.D., Mayo Clinic. Sept. 19: 10 AM, Grand rounds, Forkosh Hosp.; 6:00 PM, lecture, Lincolnwood Hyatt House. Sept. 20: 10 AM Grand rounds, Bethany Methodist Hosp. **Credit:** 5 hrs. AMA Category 1. **Fee,** deadline (for dinner only): $10, Sept. 15. **Sponsor, contact:** Shephard Plotner, FAB3-CME, Forkosh Hosp., 2544 W. Montrose, Chicago 60618; (312) 267-2200.

UPDATE ON ANTIBIOTICS
For: All physicians, nurses, paramedics. Seminar, Sept. 23. Speaker, Walter S. Wood, M.D. **Credit:** 1 hr. AMA Category 1. **Sponsor, contact:** John Huss, M.D., Memorial Hospital/DuPage County, Avon & Schiller, Elmhurst 60126.

Nephrology

SYMPOSIUM IN NEPHROLOGY
For: MDs. Speaker: Prof. H. E. deWardener, Charing Cross Hosp., London. Sept. 29. **CME Credit:** 4 hrs. AAFP Elective. **Fee:** None. **Co-Sponsors:** Christ Hospital and Am. Soc. for Clinical Pharmacology & Therapeutics. **Contact:** Christ Hospital, 4440 West 95th Street, Oak Lawn, Ill. 60453.

Neurology, Psychiatry

NEUROLOGY, PART II, CLINICAL
For: All physicians. 5½ day Course. Sept. 8-13. Chgo. **CME Credit:** 44 hrs. AMA Cat. 1. **Fee:** $225. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

Nursing Audit

NURSING AUDIT WORKSHOP
For: Nurses. Workshop. Sept. 10-12. Chgo. **Fee:** $150. **Reg. Limit:** 50; **Reg. Deadline:** Sept. 3. **Sponsor, contact:** Joint Comm. on Accreditation of Hospitals, 875 N. Michigan, Chicago, 60611. Att'n: Laurie Kidd.

Opthalmology

THE EYE IN SYSTEMIC DISEASE
For: Physicians, nurses. Lecture, Sept. 24, 1975. **Speaker:** Howard Reinglass, M.D. **Credit:** 1 hr. AMA Category 1; 2 hrs. AAFP elective. **Sponsor, contact:** Fernando Lopez-Fernandez, M.D., Martha Washington Hospital, 4055 N. Western, Chicago 60618.

Orthopaedics

SPECIALTY REVIEW COURSE IN ORTHOPAEDICS
For: Board certified or eligible applicants. 7-day Course. Sept. 7-13. Chgo. **CME Credit:** 64 hrs. AMA Cat. 1. **Fee:** $225. **Reg. Limit:** 350. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

Psychiatry

LECTURE SERIES: "PAIN AND ANGST AND THEIR ALLEVIATION"
For: Physicians and Mental Health Professionals. **Series:** Sept. '75-April '76. Sept. 17, 7:30-9:30 PM. "Rolfing." **Speaker:** Ida Rolf, Ph.D. Forest Hospital, Des Plaines, Ill. **Fee:** $90 (entire series), $15 (ind. lecture). **CME Credit:** 2 hrs. AMA Cat. 2. AAFP Elective. **Co-Sponsors:** Forest Hospital Foundation and Chicago Medical School. **Contact:** Forest Hospital, 555 Wilson Lane, Des Plaines, IL 60016. Att'n: June Bengsten.

Psychiatry

ILLINOIS PSYCHIATRIC SOCIETY WEEKEND MEETING
For: Psychiatrists and other interested professionals. 2nd Annual Fall Meeting. Sept. 26-28. O'Hare Marriott, Chicago. **Fee:** $30. **Reg. Deadline:** Sept. 25. **Sponsor, contact:** Illinois Psychiatric Society, 55 E. Monroe, Suite 3510, Chicago 60603. Att'n: Wendy Smith.

Surgery

MANAGEMENT OF COMPLICATIONS IN SURGERY
For: All physicians. 4-day Course. Sept. 29-Oct. 2. Chgo. **CME Credit:** 28 hrs. AMA Cat. 1. **Fee:** $175. **Reg. Limit:** 55. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

Trauma

CLINICAL HOSPITAL PROGRAM ON MUSCULOSKELETAL TRAUMA
For: All MDs; Interns; Residents. Two-Hour Evening Clinical Program. Sept. 23. Weiss Memorial Hospital, 4646 N. Marine Drive, Chicago. **CME Credit:** 2 hrs. AMA Cat. 1; AAFP. **Fee:** None. **Sponsor, contact:** Chicago Committee on Trauma/American College of Surgeons, 11255 W. 74th St., LaGrange, Ill. 60525 Att'n: Lillian Husa.

Urology

REVIEW COURSE IN SEXUAL DYSFUNCTION AND RELATED TOPICS
For: All physicians. 2-day Course. Sept. 29-30. Chgo. **CME Credit:** 12 hrs. AMA Cat. 1. **Fee:** $80. **Reg. Limit:** 60. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

October, 1975

Cardiology

TREATMENT OF ARRHYTHMIAS
For: Physicians, nurses, students, paramedics. **Seminar. Speaker:** Dr. William B. Dwyer. Oct. 14. Memorial Hospital of DuPage County, Elmhurst, IL. **CME Credit:** 1 hr. AMA Cat. 1. **Fee:** none. **Sponsor:** Memorial Hospital of DuPage County, Avon & Schiller Sts., Elmhurst, IL. **Contact:** John H. Huss, MD.

Family Medicine

WEBER MEDICAL CLINIC FALL SEMINAR
For: GPs. Oct. 25, 1-5 PM. **Speaker:** Richard Lynch, MD, Chief of Cardiology, SIU School of Medicine. Olney Central College Auditorium, Olney, IL. **CME Credit:** 4 hrs. AMA Cat. 1. **Fee:** none. **Reg. Limit:** 75. **Sponsor, contact:** Weber Medical Clinic and SIU School of Medicine, 1200 N. East St., Olney, IL 62450.

BASIC ELECTROCARDIOGRAPHY
For: All physicians. 5-day Course. Oct. 27-31. Chgo. **CME Credit:** 35 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 35. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

General Medicine

STATE AND NATIONAL BOARD REVIEW, COURSE, CLINICAL
For: All physicians. 6-day Course. Oct. 6-11. Chgo. **CME Credit:** 53 hrs. AMA Cat. 1. **Fee:** $225. **Reg. Limit:** 105. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

GENERAL MEDICINE LECTURE SERIES
For: Attending and House Staff. Oct. 7, 1975-June 25, 1976, 11 AM-12.30 PM. St. Mary of Nazareth Hosp. Center, Chgo. **Speaker:** Anthony Sapienza, MD. **CME Credit:** 1½ hrs. AMA Cat. 1. AAFP Elective. **Fee:** none. **Reg. Limit:** 50. **Sponsor:** St. Mary of Nazareth Hosp. Center, 2233 W. Division St., Chgo 60622. **Contact:** Anthony R. Sapienza, MD.

SEXUALITY FOR PHYSICIANS
For. All physicians. 5-day Course. Oct. 20-24. Chgo. **CME Credit:** 36 hrs. AMA Cat. 1. **Fee:** $225. **Reg Limit:** 100. **Sponsor, contact:** Cook County Grad School of Medicine, 707 S. Wood St., Chgo. 60612.

Internal Medicine

ADVANCED ELECTROCARDIOGRAPHY
For: Internists. 2½ day Course. Oct. 1-3. Chgo. **CME Credit:** 17 hrs. AMA Cat. 1. **Fee:** $125. **Reg. Limit:** 75. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

Medical Audit

MEDICAL AUDIT SEMINAR/WORKSHOP
For: Medical Records Staff and MDs. 3-Day Seminar/Workshop. Oct. 1-3. Chgo. **CME Credit:** 14 hrs. AMA Cat. 1; 16 hrs. AMRA. **Fee:** $150. **Reg. Limit:** 50. **Reg. Deadline:** week prior. **Sponsor, contact:** Joint Comm. on Accreditation of Hospitals, 875 N. Michigan, Chicago, Ill. 60611. Att'n: Laurie Kidd.

MEDICAL AUDIT TEAM SEMINAR (ADVANCED)
For: Medical Records Staff and MDs. 3-Day Seminar. Oct. 14-17. Chgo. **CME Credit:** 14 hrs. AMA Cat. 1; 16 hrs. AMRA. **Fee:** $150. **Reg. Limit:** 50. **Reg. Deadline:** week prior. **Sponsor: contact:** Joint Comm. on Accreditation of Hospitals, 875 N. Michigan, Chicago, 60611. Att'n: Laurie Kidd.

Medicine

ANTI-DEPRESSANT THERAPY
For: Physicians. Group Discussions and Lecture. Oct. 15-16. **Speaker:** Dr. Nathan S. Kline, Rockland, N.Y. Psychiatric Center, Chgo. **CME Credit:** 5 hrs. AMA Cat. 1. **Fee:** $10. (dinner only) **Reg Deadline:** Oct. 12 (dinner only) **Sponsor, contact:** FAB^3/CME, Bethany Methodist Hospital, Chicago. Att'n: Dallas Larson.

Nursing Audit

NURSING AUDIT WORKSHOP
For: Nurses. 3-day Workshop. Oct. 8-10. Chgo. **Fee:** $150. **Reg. Limit:** 50. **Reg. Deadline:** Oct. 1. **Sponsor, contact:** Joint Comm. on Accreditation of Hospitals, 875 N. Michigan, Chicago, Ill. 60611. Att'n: Laurie Kidd.

Obstetrics & Gynecology

SPECIAL COURSE IN GYNECOLOGIC PATHOLOGY
For: OB/GYN. 5-day Course Oct. 6-10. Chgo. **CME Credit:** 35 hrs. AMA Cat. 1. **Fee:** $300. **Reg. Limit:** 25. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

SPECIALTY REVIEW COURSE IN OBSTETRICS & GYNECOLOGY
For: OB/GYN. 10½ day Course. Oct. 20-31. Chgo. **CME Credit:** 86 hrs. AMA Cat. 1. **Fee:** $375. **Reg. Limit:** 85. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

Psychiatry

LECTURE SERIES: "PAIN AND ANGST AND THEIR ALLEVIATION"
For: Physicians and Mental Health Professionals. **Series:** Sept. '75-April '76. Oct. 1, 7:30-9:30 PM. "Primal Therapy." **Speaker:** Michael Holden, M.D. Forest Hospital, Des Plaines, IL. **Fee:** $30 (entire series), $15 (ind. lecture). **CME Credit:** 2 hrs. AMA Cat. 2. AAFP Elective. **Co-Sponsors:** Forest Hospital Foundation and Chicago Medical School. **Contact:** Forest Hospital, 555 Wilson Lane, Des Plaines, IL. 60016.

GENERAL PSYCHIATRIC STUDY GROUP
For: Psychiatrists. Oct., '75-May, '76. Third Sat. of each month. Chgo. **CME Credit:** 24 hrs. AMA Cat. 1. **Fee:** $125. **Reg. Limit:** 12, **Sponsor, Contact:** Institute of Psychiatry, Northwestern U. Med. School, 320 E. Huron St., Chicago, Ill. 60611. Att'n: Dr. Barbara A. Kay.

PSYCHOANALYTIC STUDY GROUP
For: Psychiatrists. Oct., '75-May, '76. First Sat. of each month. Chgo. **CME Credit:** 24 hrs. AMA Cat. 1. **Fee:** $125. **Reg. Limit:** 12. **Sponsor, contact:** Institute of Psychiatry, Northwestern U. Med. School, 320 E. Huron St., Chicago, Ill. 60611. Att'n: Dr. Barbara A. Kay.

PREVENTION PROGRAMS FOR ALCOHOLISM
For: Psychiatrists. Distinguished Lecture Series. **Speaker:** Morris E. Chafetz, MD. Oct. 15, 8:00 p.m. Chgo. **CME Credit:** 1½ hrs. AMA Cat. 1. **Fee:** None. **Sponsor, contact:** Institute of Psychiatry, Northwestern U. Med. School, 320 E. Huron St., Chicago, Ill. 60611. Att'n: Dr. Barbara A. Kay.

Surgery, Gynecology

DIAGNOSIS AND TREATMENT OF CANCER OF THE BREAST
For: Surgeons, OB/Gyn, Internists, FPs. Symposium. Oct. 15. Itasca, Ill. **CME Credit:** 3 hrs. AMA Cat. 1; AAFP Elective. **Fee:** None. **Reg. Deadline:** Oct. 13. **Co-Sponsors:** DuPage County Med. Soc. and American Cancer Soc. **Contact:** DuPage County Medical Society, 646 Roosevelt Rd. Glen Ellyn, Ill. 60137. .

Trauma

CLINICAL HOSPITAL PROGRAM ON MUSCULOSKELETAL TRAUMA
For: All MDs. 2-Hour Evening Clinical Program. Oct. 21. Chgo. **CME Credit:** 2 hrs. AMA Cat. 1; AAFP Elective. **Fee:** None. **Sponsor, contact:** Chicago Committee on Trauma/American College of Surgeons, 11255 W. 74th St., LaGrange, Ill. 60525. Att'n: Lillian Husa.

MANAGEMENT OF COMMON FRACTURES AND DISLOCATIONS
For: All physicians. 5-day Course. Oct. 27-31. Chgo. **CME Credit:** 35 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 30. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

ANNOUNCEMENT

The Institute of Psychiatry, Northwestern University Medical School has been accredited to offer Category I credit toward The American Medical Association's "Physician's Recognition Award."

The Distinguished Lecture Series and Two Study Groups are planned for 1975-1976. Information can be obtained by calling: 312/649-8050.

November, 1975

Anesthesia

ANESTHESIA FOR HEAD AND NECK SURGERY
For: All MDs 3-Day Course. Nov. 20-22. Chgo. **CME Credit:** 22 hrs. AMA Cat. 1. **Fee:** $250. **Reg. Limit:** 50. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

Family Medicine

PSYCHIATRY FOR THE MEDICAL PRACTITIONER
For: All MDs. 3-Day Course. Nov. 5-7. Chgo. **CME Credit:** 24 hrs. AMA Cat. 1. **Fee:** $175. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

UROLOGY FOR THE GENERAL PRACTITIONER
For: FPs. 2-Day Course. Nov. 13-14. Chgo. **CME Credit:** 16 hrs. AMA Cat. 1. **Fee:** $75. **Reg. Limit:** 50. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

Internal Medicine

ADVANCES IN MEDICINE
For: Internists. 5-Day Course. Nov. 17-21. Chgo. **CME Credit:** 35 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 50. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

MEDICAL AUDIT PROCEDURE SEMINAR/WORKSHOP
For: Medical Records Staff and MDs. 3-Day Seminar/Workshop. Nov. 5-7. Chgo. **CME Credit:** 14 hrs. AMA Cat. 1; 16 hrs. AMRA. **Fee:** $150. **Reg. Limit:** 50. **Reg Deadline:** 1 week prior. **Sponsor: contact:** Joint Comm. on Accreditation of Hospitals, 875 N. Michigan, Chicago, 60611. Att'n: Laurie Kidd.

MEDICAL AUDIT TEAM SEMINAR (ADVANCED)
For: Medical Records Staff and MDs. 3-Day Seminar. Nov. 19-21. Chgo. **CME Credit:** 14 hrs. AMA Cat. 1; **Fee:** $150. **Reg. Limit:** 50. **Reg. Deadline:** 1 week prior. **Sponsor, contact:** Joint Comm. on Accreditation of Hospitals, 875 N. Michigan, Chicago 60611. Att'n: Laurie Kidd.

Medicine

THE MANAGEMENT OF BREAST CANCER
For: Physicians. Group Discussions and Lecture. Nov. 7-8 **Speaker:** Dr. Sheldon Kaufman, Massachusetts General Hospital, Chgo. **CME Credit:** 5 hrs. AMA Cat. 1. **Fee:** $10 (dinner only). **Reg. Deadline:** Nov. 3 (dinner only). **Sponsor, contact:** FAB^3/CME, Belmont Community Hospital, Chicago. Att'n: John McCracken.

TUBLO INTERSTITIAL RENAL DISEASE
For: MDs and Nurses. Lecture. **Speaker:** Wadi N. Suki, MD, Baylor College, Houston, Tex. Nov. 5. **CME Credit:** 1 hr. AMA Cat. 1. AAFP. **Fee:** none. **Sponsor, contact:** Martha Washington Hospital, 4055 N. Western Ave., Chicago, Ill. 60618. Att'n: Fernando Lopez-Fernandez, MD.

Nursing Audit

NURSING AUDIT WORKSHOP
For: Nurses. 3-Day Workshop. Nov. 12-14. Chgo. **Fee:** $150. **Reg. Limit:** 50. **Reg. Deadline:** Nov. 5. **Sponsor, contact:** Joint Comm. on Accreditation of Hospitals, 875 N. Michigan, Chicago, 60611. Att'n: Laurie Kidd.

Professional Liability

ONE-DAY WORKSHOP
For: MDs, Attorneys, Hospital Administrators. **Speaker:** Roger O. Egeberg, M.D. Nov. 7. Hyatt-Regency, Chicago. **Fee:** $40-members; $45-non-members. **Sponsor, contact:** Institute of Medicine of Chicago, 332 S. Michigan Ave., Chicago, Ill. 60604.

Otorhinolaryngology

ANNUAL OTOLARYNGOLOGIC ASSEMBLY
For: Otolaryngologists. Nov. 8-14, Chgo. **CME Credit:** 40 Hrs.. AMA Cat. 2. **Fee:** $350. **Sponsor, contact:** U. of Ill. Abraham Lincoln School of Med., 1855 W. Taylor St., Chicago, Ill. 60612. Att'n: Marion B. Wickland.

Plastic Surgery

MANAGEMENT OF SKIN TUMORS
For: MDs, paramedics, students. Seminar. Nov. 4. Elmhurst. **CME Credit:** 1 hr. AMA Cat. 1. **Fee:** None. **Sponsor, contact:** Memorial Hospital of DuPage County, Avon & Schiller, Elmhurst, Ill. 60126. Att'n: John H. Huss, M.D.

Psychiatry

FINANCING PSYCHIATRIC SERVICES
For: Psychiatrists. Distinguished Lecture Series. **Speaker:** Walter Barton, MD, Dartmouth Med. School. Nov. 19. Chgo. **CME Credit:** 1½ hrs. AMA Cat. 1. **Fee:** None. **Sponsor, contact:** Institute of Psychiatry, Northwestern U. Med. School, 320 E. Huron St., Chicago, Ill. 60611. Att'n: Dr. Barbara A. Kay.

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

ALBANY: Small town on bank of Mississippi river needs general practitioner. Ideal modern brick building with parking area available. Two recently new, well equipped hospitals at Clinton—8 miles away. Nice community, two factories nearby. Contact: Mrs. Warden Welch, Park Street, Box 441, Albany 61230 (309-887-4461) (10)

AURORA—Board eligible or certified gynecologist to join established corporation in town of 75,000—30 miles west of Chicago. Guaranteed salary 1st year with partnership arrangements thereafter. Option to buy in anytime. G. J. Shimkus, M.D., 143 So. Lincoln Ave., Aurora, 60505. 312-896-7892. (1)

BELLEVILLE: Pulmonary Disease Specialist—Part Time Director wanted for modern 329 bed full service community hospital with extensive building program. Complete specialty backup. 500,000 served by local hospitals. No pulmonary specialist in hospital or private practice. Contact: Matthew Eisele, M.D., Memorial Hosital, 4501 North Park Drive, Belleville, 62223. (618) 233-7750, Ext. 345 (11)

BELLEVILLE: Emergency Medical Services Director wanted for modern 329 bed full service community hospital. Areawide Trauma Center. Emergency Department expanding to 10,900 square feet. Full time physician coverage since January, 1971. Complete specialty backup. Financial arrangements negotiable. Contact: Matthew Eisele, M.D., Memorial Hospital, 4501 North Park Drive, Belleville, 62223. (618) 233-7750, Ext. 345. (11)

BLOOMINGTON — General Practitioners urgently needed. Guaranteed salary with percentage of the business done. Excellent opportunity for energetic young physicians. For further information contact—P. G. Theobald, M.D., President, Theobald Medical Center, #1 Medical Hills Drive, Bloomington, 61701. (9)

BOLINGBROOK—28,000 population, fast growing. Fastest growing community in the state. Short on Professional services, particularly physicians and dentists. 30 miles from Chiago Loop, conveniently located at the intersection of I-55 and Rt. 53. Openings for Family Medicine, Internist, Surgeon, OB-GYN in new Professional Building. Occupancy April-May 1975. Contact: James Pontoriero, M.D., (312) 739-5121. (9)

CARBONDALE: A Board Certified or Eligible Radiologist is wanted to join a Board Certified Radiologist in a 30 man multi-specialty clinic in Southern Illinois. A large university and new medical school are located in the community. Excellent starting salary, teaching opportunities and fringe benefits. Contact: Wayne Given, Carbondale Clinic, PO Box 2347, Carbondale 62901. (10)

CARMI: Unusually attractive opportunity. Join three Family Physicians in southern Illinois community with drawing population of 18,000. Office adjacent to fully accredited Family Physician Hospital. Guaranteed income first year. Early partnership. Must investigate to appreciate. Call collect days: 618-382-8303; evenings: 618-382-4008. (10)

CARROLLTON: Ample excellent opportunities in Greene County for Family physician. Group practice being set up in new office accommodating 4-5 M.D.'s next to hospital. For further information contact: Dr. Caselton, or Dr. Chung or Roy Shoemaker, 800 School Street, Carrollton 62016 (217-942-6946) (9)

CHADWICK: Town needs DOCTOR—have been without Doctor since former retired. Complete office building—available for immediate use. Location in center of rich farming community—good recreational facilities nearby. A very good place to live. Contact: Frank W. Mest, POB 148, Chadwick 61014 (815-684-5173) (10)

CHICAGO: Medical Center N.W. Side of Chicago with clinical laboratory, X-rays, physical therapy. 2 Family Physicians, members A.A.P.F., looking for a young, well trained, ambitious F.P. Privileges in hospital with Department of Family Practice, F. S. Steinitz, M.D., 3653 W. Lawrence, Chgo. 60625 (312-478-6600). (12)

GALENA: Pop. 4,500. Family/General Practitioner wanted to join three other FPs in county seat town. Complete office facilities adjacent to new 32-bed hospital and 34-bed skilled nursing care facility. Fifteen miles from city of 65,000. This historically rich community nestled in the Galena river valley and hillside offers a very good school system, numerous churches, outstanding recreational facilities (golf courses, ski lodge, swimming pool, tennis courts, fishing, boating and water skiing). Contact Dr. W. E. Johnson, 300 Summit St., Galena, 61036 - Tel. (815) 777-0900. (9)

LITCHFIELD: GP's & Peds. Located on I 55 midway between Springfield & St. Louis. Office space available in new medical arts building. Guaranteed income and other financial assistance available. New 140 bed hospital with full time ER coverage by trauma center physicians. Practice opportunities unlimited. Contact: Lee Johnson, M.D., St. Francis Hospital (217-324-2191) or John Short, 723 N. Van Buren, Litchfield 62056 (217-324-3937). (10)

MURPHYSBORO: Population 10,000. Wanted FP and OB-GYN to associate with 3-man group: 1 surgeon, 1 FP, 1 internist. Six miles from S.I.U. Good schools. Beautiful lakes for recreation. Good fringe benefits. Contact Medical Arts Clinic, Ltd., W. J. Borgsmiller, President. 215 N. 14th, Murphysboro, 62966. (618) 684-2172. (9)

BLUE SHIELD REPORT FOR Illinois Physicians

Fall Series of Workshops for Medical Assistants Continuing

The Blue Shield Plan of Illinois Medical Service has scheduled a series of fall workshops for medical assistants in Kane, Will, DuPage, Lake and Cook Counties. Workshops have been held in Kane and Will Counties thus far in the series.

Those remaining in September are:

Wed., Sept. 17	Stouffer's Inn	Oak Brook
Thurs., Sept. 18	Ramada Inn	Hinsdale
Wed., Sept. 24	Sheraton-Waukegan	Waukegan

October and November, 1975 workshops in Cook County are:

Wed., Oct. 1	Holiday Inn	Harvey
Wed., Oct. 8	Oak Park Arms	Oak Park
Wed., Oct. 15	Holiday Inn	Evanston
Wed., Oct. 22	Arlington Towers	Arlington Heights
Thurs., Oct. 23	Hyatt House	Chicago
Wed., Oct. 29	Sheraton Inn	Oak Lawn
Thurs., Oct. 30	McCormick Inn	Chicago
Wed., Nov. 5	Drake Hotel	Chicago
Thurs., Nov. 6	Continental Hotel	Chicago

Invitational letters have been sent to physicians' offices in the above counties with reservation forms, giving the locations and dates. For additional information, please write or telephone Mrs. Loretta O'Donnell, Professional Relations Department, Blue Shield Plan of Illinois Medical Service, 233 North Michigan Ave., Chicago Illinois 60601. Phone (312) 661-2964.

Workshops are conducted by the staff of the Professional Relation's Department. Medical assistants have a choice of attending either morning or afternoon sessions. Mornings programs begin with registration at 8:30 A.M.; workshops are from 9:00 A.M.—12:00 noon. Registration for the afternoon session begins at 1:00 P.M., following luncheon at 12:15. The afternoon program begins at 1:30P.M. and ends at 4:30 P.M. All participating medical assistants are invited to the luncheon.

Those attending will be assigned to either Beginners of Advanced groups; a member of our staff will serve as instructor for each group. Programs will include review of material in the Medical Assistant's Handbook; Usual and Customary Basis of Payment; information in the Blue Shield Reports for Medical Assistants; Physician's Service Reports, How to Prevent Payment Delays and a review of the Reciprocity Program. Workshops in Cook County will also emphasize discussions of Medicare changes and a review of the Medicare Handbook.

Coordination of Benefits

In many families today both spouses are employed and quite often are covered by family contracts involving two different health care programs. If either husband or wife becomes ill, it is possible for them to collect from both health care programs. Frequently they can and do collect in excess of the actual cost of the illness. To avoid these unnecessary costs, employers have included non-duplication provisions in their contracts, commonly called "coordination of benefits."

COB is a group contract provision designed to limit the combined payment of two health care programs to no more than the *total* charges incurred. Most Blue Cross-Blue Shield groups and employer insurance programs now incorporate this provision in their contracts. Our Plans are in agreement with most other health benefit underwriters on certain basic rules in determining which carrier will have primary liability when two or more coverages are involved and either or both have coordination of benefits provisions:

(1) The health care plan in which the patient is insured has the primary responsibility. The spouse's group plan has secondary responsibility for health care cost not covered by the primary carrier.

(2) When a dependent child receives care, the father's group plan, provided he has a family plan, has primary responsibility.

(3) When the patient is covered under two group plans as an employee, the plan under which he has been covered for the longest time is considered primary.

Health care plans which an employee or member of the employee's family purchase as an individual (not through a group) are *not affected* by the COB provisions outlined above.

It is the responsibility of the insurance carriers to determine the *extent* of liability of the companies or Plans involved. Providing as much information as possible to each carrier about other coverage in force will expedite this process, reduce correspondence and prevent unnecessary delays.

Coverage of Laboratory Services and Identification of Sources

Diagnostic laboratory services furnished by an independent laboratory are covered only if the services are related to the patient's illness or injury and ordered by a physician.

Physicians must also identify the sources of laboratory services to avoid payment delays on either the SSA-1490 Request for Medicare Payment form or billing statement submitted to the Part B carrier.

If the SSA-1490 form is used for a laboratory service furnished outside the physician's office, the laboratory must be identified in item 13 and the letters "IL" placed in item 7B. If the physician performs the laboratory service in his own office, an "O" is placed in item 7B. Claims that were formerly accepted without an indication that the test was performed in a physician's office will no longer be routinely processed by the Medicare carrier.

Other regulations covering laboratory services are:

(1) When a physician orders tests from an independent clinical laboratory, it must be one certified in its specialty or specialties by the Social Security Administration. The laboratory must also agree to perform tests for patients covered by Medicare only in the specialty or specialties for which it is certified. If it performs a test for which it is not certified the claim for services will be denied.

(2) If a test or other laboratory service is referred from one independent laboratory to another, the laboratory performing the test must be certified in the specialty. The name of the laboratory performing the test should be made known to the physician and identified on the SSA-1490 form.

(3) Screens, profiles and automated tests are covered by Part B Medicare and the test need not be listed with separate charges. However, the name of each test and total charge for the group of tests must be shown on the SSA-1490 form or attached itemized statement.

(4) Physicians may charge a drawing fee. Denial of coverage for a laboratory test does not affect coverage of the office visit which usually includes the physician's charge for evaluating and interpreting the laboratory report.

Drugs and Biologicals

Payment for drugs and biologicals are made under Part B Medicare if the injections (1) cannot be self-administered (2) are not immunizations (3) are reasonable and necessary for the diagnosis or treatment of the illness or injury (4) meet all the general requirements of items furnished incident to a physician's service, i.e. administered by him or his nurse under his personal supervision.

To be properly reimbursed for injections the following information should be itemized on the billing statement or SSA-1490 form: (1) date and place of the service (2) name of the drug injected (3) actual dosage given (4) diagnosis (5) specific charge for the injection (apart from the charge for the office visit).

When the name of the drug is given, but the injection charge *is not broken out separately from the office visit,* the carrier will determine if the drug is covered, and if so, *will reimburse for the office visit, plus the minimum reasonable charge for the drug injection.*

If the actual dosage is not given, the carrier's reimbursement is based on the most common dosage.

If the physician does not give the name of the drug injected, the carrier will reimburse *only for the office visit,* because without the drug's identification the carrier cannot determine if it is covered by Medicare.

SSA Changes in Lab Certifications

Effective May 15, 1975 the Mason-Barron Laboratories located at the following addresses were made drawing stations and their provider number was retired. They refer their diagnostic and clinical laboratory services to Mason-Barron's certified laboratories. The addresses are:

Mason-Barron Laboratory
64 Old Orchard Road
Skokie, Illinois 60076
Provider Number: 14-8176

Mason-Barron Laboratory
200 East Willow
Wheaton, Illinois 60187
Provider Number: 14-8106

Mason-Barron Laboratory
533 West North Avenue
Elmhurst, Illinois 60126
Provider Number: 14-8184

Mason-Barron Laboratory
120 Oak Brook Center Mall
Hinsdale, Illinois 60521
Provider Number: 14-8242

Mason-Barron Laboratory
1950 Sheridan Road
Highland Park, Illinois 60035
Provider Number: 14-8033

The following laboratory is under new ownership through incorporation:

Affiliated Medical Laboratories, Inc.
6785 West 174th Street
Tinley Park, Illinois 60477
Effective Date: April 1, 1975
Provider Number: 14-8197

The laboratory below closed on July 1, 1975:

S & S Medical Laboratory
532 East 47th Street
Chicago, Illinois 60653
Provider Number: 14-8156

IMJ
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3rd District: 1978,

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326 Fairway Dr., Bloomington 61701
6th District: 1978, Robert R. Hartman, M.D.
1515 A. W. Walnut, Jacksonville 62650
7th District: 1976, Arthur F. Goodyear, M.D.
142 E. Prairie, Decatur 62523
8th District: 1976, Eugene P. Johnson, M.D.
P.O. Box 68, Casey 62420
9th District: 1978, Warren D. Tuttle, M.D.
203 N. Vine St., Harrisburg 62946
10th District: 1978, Julian W. Buser, M.D.
6600 W. Main, Belleville 62223
11th District: 1977, Ross Hutchison, M.D.
126 E. Ninth St., Gibson City 60936
Trustee-At-Large: 1976, Fredric D. Lake, M.D.
1041 Michigan, Evanston 60202
Chairman of the Board: Joseph L. Bordenave, M.D.
415 South Second Street, Geneva 60134

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And for those with trouble staying asleep or sleeping long enough...

...sleep research laboratory clinical studies prove: Dalmane decreases number of nighttime awakenings and increases total sleep time.[5]

Dalmane (flurazepam HCl) is relatively safe, seldom causes morning "hang-over"

Dalmane is generally well tolerated. The usual adult dose of 30 mg should initially be lowered to 15 mg for the elderly and debilitated, to help preclude oversedation, dizziness or ataxia. Appraisal of possible risks is suggested before prescribing.

REFERENCES:

1. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington DC, May 3-7, 1971
2. Frost JD Jr: A system for automatically analyzing sleep. Scientific exhibit at the 24th annual Clinical Convention of the American Medical Association, Boston, Nov 29-Dec 2, 1970; and at the 42nd annual scientific meeting of the Aerospace Medical Association, Houston, Apr 26-29, 1971
3. Vogel GW: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
4. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
5. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

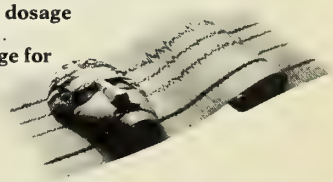
Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

You can depend on the efficacy of

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.



for insomnia

Objectively proved in the sleep research laboratory:
- **sleep within 17 minutes, on average**
- **sleep with fewer nighttime awakenings**
- **sleep for 7 to 8 hours, on average, with a single *h.s.* dose**

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Abstracts of Board Actions

August 2-3, 1975 **Chicago**

House of Delegates

The Board of Trustees authorized a special session of the House of Delegates to determine the course of action to be taken with respect to: (1) The continuing professional liability crises; and (2) ISMS' relationship with state government agencies, such as the Departments of Public Aid and Registration and Education. The Illinois Delegation to the AMA will hold an Open Forum in conjunction with the meeting.

The meeting will be held in Springfield, to coincide with the fall session of the General Assembly. Delegates and county medical societies will be provided with full details, including instructions on submitting resolutions.

The 1976 annual meeting of the House of Delegates will be April 25-28 at the Palmer House in Chicago.

Medicaid

Members of the Board strongly protested recent action of the governor and the Public Aid Department in cutting Medicaid reimbursements for physicians, hospitals and pharmacies, indicating that the cutbacks will jeopardize the availability of health care to the poor. ISMS representatives were to meet August 4 with other health care providers to develop a united stand. A press conference was to be scheduled August 7, following the meeting to explain how across-the-board cuts will affect services and drugs available to public aid recipients.

In a related action, the Board directed the Committee on Government Health Reimbursement Programs to gather data and develop a comprehensive profile of the problems associated with reimbursement from the Department of Public Aid.

Chiropractors

The Executive Committee was given authority to proceed at its discretion with legal action to: (1) Enjoin the Department of Registration and Education from implementing regulations which would allow chiropractors to perform acupuncture; and (2) Require the Department to cease all chiropractic licensure under the National Chiropractic Examination and call on the Department to show why they should continue to license chiropractors in this manner.

The action followed a report that the Medical Examining Committee had ruled that acupuncture is not a surgical procedure and thus could be performed by chiropractors. To allow ISMS to address itself to the issue, the Board requested Medical Legal Council to re-evaluate the Society's position on acupuncture and define chiropractic with a view to introducing legislation to control both.

In a related action, the Board approved a position statement that PAP smears should be performed only under the direct supervision of a physician licensed to practice medicine and surgery in all its branches. This action resulted from the Medical Examining Committee's recommendation that chiropractors be allowed to perform PAP smears.

Professional Liability

ISMS will urge the governor to sign SB 1024, the medical malpractice bill passed by the General Assembly, despite an amendment which requires all companies writing malpractice insurance in Illinois to justify rate increases for approval by the Department of Insurance.

Joel Edelman, an attorney and former director of the Illinois Department of Public Aid, has been retained as a consultant to the ISMS Task Force on Professional Liability, an inter-specialty group formulating a comprehensive, long-range solution to the malpractice dilemma.

In related actions, the Board:

1. Requested the Task Force on Professional Liability to develop a self-insured liability plan as a contingency in case the Hartford should withdraw from the ISMS sponsored program.
2. Received legal counsel's opinion on the elements that must be present in order to file a successful counter-claim in a malpractice case and directed the Medical Legal Council to continue looking for the appropriate situation to carry out the mandate of the last House of Delegates.
3. Provided the secretary-treasurer with standby authority to collect $10 assessment approved by the House of Delegates to file counterclaims.
4. Directed that peer review committees be informed of the action taken on insurance applications which the committee has reviewed.
5. Authorized the Insurance Committee to consolidate its peer review operations downstate into two large areas rather than in individual trustee districts.

Medical Protective Association

The Board agreed to establish liaison with the Medical Protective Association of Illinois, but declined an invitation to name a representative to the board of directors of this organization, which was formed to protect the legal interests of physicians.

Billing for Supervising Nurse Anesthetists

On advice of legal counsel, the Board adopted a position that a surgeon operating on a patient should not charge for supervising nurse anesthetists while performing surgery.

Physician Assistants

ISMS will continue to support SB 739, the physician assistant bill, despite objections of the Illinois Association of Ophthalmologists, which will urge Governor Walker to veto the bill because it prohibits physician assistants from performing services currently reserved to optometrists.

Dr. Cloninger Resigns

Dr. Samuel Cloninger, who has elected a Third District Trustee in April, has resigned from the Board for reasons of health. A replacement will be named at the Board's November meeting.

AMA Nominations

Dr. Robert T. Fox, Glenview, was nominated for appointment to the AMA Council on Scientific Assembly. Dr. Robert P. Johnson, Springfield, was nominated for the Committee on Maternal and Child Care.

Nominations for State Appointments

Drs. Austin Gibbons, Elgin, Ronald Kowalski, Peoria, and John Holland, Springfield, were nominated for appointment to the Advisory Board on Necropsy Service to Coronors. Nominations are being sought to fill a vacancy created by Dr. V. P. Siegel's recent resignation from the Hospital Licensing Board.

(Continued on page 261)

THE NATURAL WAY

For more than thirty years PREMARIN (Conjugated Estrogens Tablets, U.S.P.) has been prepared with natural equine estrogens exclusively—without synthetic estrogen supplements. For more than thirty years it has provided the complete estrogen complex in the proportions found in its natural source. And for more than thirty years PREMARIN has enjoyed an unparalleled record of clinical efficacy and acceptance.

PREMARIN. The only estrogen preparation available that contains natural estrogens exclusively and also meets all U.S.P. specifications for conjugated estrogens. Assurance of quality for you and your patients.

PREMARIN . . . naturally.

RIEF SUMMARY
or full prescribing information, see package rcular.)
REMARIN®
Conjugated Estrogens Tablets, U.S.P.)

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

ntraindications: Short acting estrogens are ntraindicated in patients with (1) markedly paired liver function; (2) known or suspected cinoma of the breast, except those cases of gressing disease not amenable to surgery or adiation occurring in women who are at least ears postmenopausal; (3) known or suspected rogen-dependent neoplasia, such as carcima of the endometrium; (4) thromboembolic orders, thrombophlebitis, cerebral embolism, in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
rnings: Estrogen therapy should not be given women with recurrent chronic mastitis or abmal mammograms except, if in the opinion of physician, it is warranted despite the possibilof aggravation of the mastitis or stimulation ndiagnosed estrogen-dependent neoplasia.
The physician should be alert to the earliest nifestations of thrombotic disorders (thromphlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest

Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000.

No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000. 7352

PREMARIN®

AND OF CONJUGATED ESTROGENS TABLETS, U.S.P.

CONTAINS ONLY NATURAL ESTROGENS ...NO SYNTHETICS OR SUPPLEMENTS

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AYERST LABORATORIES
New York, N.Y. 10017

Obituaries

*Andrews, H.C., Georgia, died June 21 at the age of 69. Dr. Andrews graduated from Northwestern University in 1933 and was founder of Central Hospital in Clifton now known as Interstate Hospital.

*Coombs, James, Park Ridge, died March 8 at the age of 68. Dr. Coombs graduated from the University of Cincinnati in 1937.

*Corcoran, Charles, Chicago, died July 11 at the age of 58. Dr. Corcoran graduated from Loyola Medical School in 1944.

**Dragstedt, Lester, Florida, died July 16 at the age of 82. Dr. Dragstedt graduated from Rush Medical School in 1921.

*Davis, Chester, Lincoln, died June 9 at the age of 78. Dr. Davis graduated from University of Chicago in 1931. He was also a past president of the Logan County Medical Society.

**Davis, Irwin, Belleville, died July 2 at the age of 75. Dr. Davis graduated from University of Illinois in 1925.

**Heiligenstein, Rudolph, Belleville, died June 10 at the age of 86. He graduated from Loyola University in 1916. Dr. Heiligenstein was a past president of the St. Clair County Medical Society.

*Kizer, Betty, Glen Ellyn, died July 23 at the age of 53. Dr. Kizer graduated from the University of Illinois in 1949.

*Macaluso, Donald, Chicago, died July 18 at the age of 35. Dr. Macaluso graduated from Stritch Medical School in 1966.

*Mishkin, Herman, Chicago, died July 26 at the age of 75. Dr. Mishkin graduated from University of Illinois in 1926.

*Schaller, C. H., Arizona, died June 19 at the age of 79. Dr. Schaller graduated from Rush Medical School in 1921.

*Siegel, Harry, Chicago, died July 10 at the age of 57. Dr. Siegel graduated from Chicago Medical School in 1943.

*Stuttle, Fred, Peoria, died June 11 at the age of 69. He graduated from University of Illinois in 1930. Dr. Stuttle was named president-elect of the Illinois State Orthopedic Society at its annual meeting in November.

*Wilson, Earl, Oak Park, died Feb. 19 at the age of 70. Dr. Wilson graduated from Rush Medical College in 1933.

**Indicates ISMS member.*

***Indicates ISMS member and member of the Fifty Year Club.*

EAR PIERCING MEDICAL PROCEDURE

Director Ronald E. Stackler, of the Department of Registration and Education warned that registered nurses may not perform ear piercing which is classified as a medical procedure to be performed only by licensed physicians. Regulations governing ear piercing were recently liberalized to include all physicians licensed under the Medical Practice Act (medical doctors, chiropractors and osteopaths). The new rules, however, do not include nurses. Stackler said that any nurse performing ear piercing operations would be doing so illegally and would risk license suspension or revocation.

DARVOCET-N® 100

propoxyphene napsylate with acetaminophen

Indication: For the relief of mild to moderate pain, either alone or accompanied by fever.

Contraindications: Hypersensitivity to propoxyphene or to acetaminophen.

Warnings: *Drug Dependence*—Propoxyphene can produce drug dependence characterized by psychic dependence and, less frequently, physical dependence and tolerance. Propoxyphene will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to that of codeine although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine. *Usage in Ambulatory Patients*—Propoxyphene may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, such as driving a car or operating machinery. The patient should be cautioned accordingly. *Usage in Pregnancy*—Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, propoxyphene should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards. *Usage in Children*—Propoxyphene is not recommended for use in children, because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric age group.

Precautions: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The central-nervous-system depressant effect of propoxyphene may be additive with that of other C.N.S. depressants.

Adverse Reactions: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, lightheadedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses exceeding 800 mg. per day has caused toxic psychoses and convulsions.

[011375]

DARVON® COMPOUND-65

propoxyphene hydrochloride, aspirin, phenacetin, and caffeine

Indication: For the relief of mild to moderate pain.

Contraindication: Hypersensitivity to propoxyphene, aspirin, phenacetin, or caffeine.

Warnings: *Drug Dependence*—Propoxyphene can produce drug dependence characterized by psychic dependence and, less frequently, physical dependence and tolerance. Propoxyphene will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to that of codeine although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine. *Usage in Ambulatory Patients*—Propoxyphene may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, such as driving a car or operating machinery. The patient should be cautioned accordingly. *Usage in Pregnancy*—Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, propoxyphene should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards. *Usage in Children*—Propoxyphene is not recommended for use in children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric age group. Salicylates should be used with extreme caution in the presence of peptic ulcer or coagulation abnormalities.

Precautions: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The central-nervous-system depressant effect of propoxyphene may be additive with that of other C.N.S. depressants. Phenacetin has been reported to damage the kidneys when taken in large amounts for a long time. Salicylates may enhance the effect of anticoagulants and inhibit the uricosuric effect of uricosuric agents.

Adverse Reactions: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, lightheadedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses exceeding 800 mg. per day has caused toxic psychoses and convulsions.

[011375]

Additional information available to the profession on request.

Eli Lilly and Company, Inc.
Indianapolis, Indiana 46206

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Relief from her arthritic pain

Darvocet-N®100

100 mg. propoxyphene napsylate and
650 mg. acetaminophen

contains no aspirin

Darvon® Compound-65

65 mg. propoxyphene hydrochloride, 227 mg. aspirin,
162 mg. phenacetin, and 32.4 mg. caffeine

contains aspirin

for mild to moderate pain

See summary of prescribing information on adjoining page.



Editorials

'Plucked' by Legal Eagles

The legal profession has a decided advantage over the medical profession.

According to the business magazine, *Forbes,* few laymen have a precise idea of what lawyers do—mainly because the legal establishment seems to want it that way. To them, the profession's code of ethics against self-advertising outweighs the public's right to know a little about what an influential law firm actually does.

Forbes quotes Martin Mayer in *The Lawyers*: "Professional secrecy has both protected the bar from criticism of the kind that improves performance and stimulated criticism of the kind that shakes confidence."

Twenty years ago when medical societies opened up their meetings to the media, within hours, the public knew more about what the medics discussed than did the members who did not attend. In print, suddenly was all of our dirty linen, and the minute details of how we felt about venereal diseases, fees, poorly-qualified colleagues, ethics, care of the poor and indigent, government medicine, etc. The next step was to hire a public relations agency, and from then on the activities of a Medical society were like an open book.

In my opinion, many of our current problems can be traced to loss of professional secrecy. This is understandable because the media always has the last word. If Tuesday's front page medical story warrants a retraction, we'd be hard put to find it buried on page 10!

It will be most interesting to see what the legal profession does in the next 10 years. During the past 30 or 40 years, Americans have become more legal minded. More people were starting new businesses, getting divorces, or dying and leaving wills and estates. Mergers and bankrupcies almost tripled. Real estate deals flourished, auto traffic accidents soared, and corporate problems became more complicated.

Tax regulations have become knottier and knottier, and our government regulations more complex. It takes a Harvard lawyer to figure out the legal ramifications of government-related activities. And this does not even include the legal aspects of crime and the decreasing number of judges who are also lawyers.

Ostensibly, to "protect" the public, the American Bar Association has set minimal fees. But nothing is said about maximum fees. In some cases, costs are calculated by the hour. In others, cost represents a percentage of the monies involved, and still others, a percentage (33 per cent) of any amount awarded to the victim of an accident or malpractice suit.

The fee also includes the lawyer's expenses. In the end, he gets almost as much as the plaintiff. A Federal study revealed that of $1.4 billions awarded in 220,000 accident cases, auto victims got only $700 million while the lawyers got $600 million. The remaining $100 million went for legal expenses. This, of course, is the objection to the large malpractice awards that the public has been led to believe go to the mistreated patient.

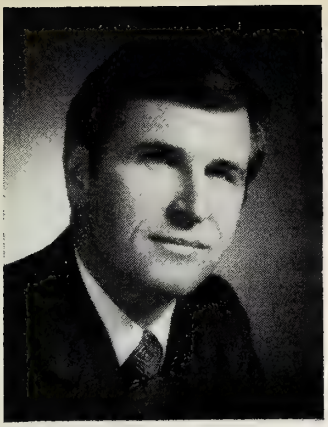
But lawyers are in for a change—in attitudes and fees—as many are pricing themselves out of business. Most poor and blue collar workers cannot afford their services despite Legal Aid and the Office of Economic Opportunity.

Yet lawyers have never had it so good. According to *Forbes,* they dominate politics, and have many top spots in American business. Economically they are booming. The top men in our giant corporations draw salaries in the $250,000 range. Literally hundreds of lawyers do much better than that. There are roughly 50 leading law firms in the country whose prominent partners routinely make $200,000 to $500,000 a year.

T. R. Van Dellen, M.D.
Editor

Reference

"All About Lawyers." *Forbes* (Sept. 15) 1971.



President's Page

"An Interesting Time"

As I have been involved in the past few months with the multi-faceted problems of malpractice, Illinois Department of Public Aid and Illinois Department of Registration and Education, I cannot help but paraphrase that medical phrase "an interesting case," and apply it to the time that we have gone through as "an interesting time" with all of its varied meanings. These past months have solidified my feeling that the more remote the decision-making, the more unlikely it is that the decision made will apply to the original problem.

During the evaluations of these recent problems, it has seemed to be increasingly self-evident that government cannot practice the *art* of medicine. It can only attempt to regulate, study or computerize the mechanics of medical care delivery.

In so doing, government makes it more difficult for the patient to receive person-to-person care and true *personal* "health" concern. It seems that as government equates dollars, statistics and studies with the *care* of patients, it succeeds in totally removing the personal touch. And it decreases the time available for treating patients by its demands for increased paperwork. Ultimately, government succeeds in increasing the cost for services rendered by creating a need for more personnel to restore the person-to-person care that government itself was responsible for removing.

Since it remains as true now as ever that "health care" is a person-to-person concern and is accomplished by interaction given from one with experience and talent to one seeking help, it becomes increasingly mandatory that we retain and actually reinforce the course upon which we have embarked in the past few months.

Our efforts in the malpractice dilemma will need to be intensified. We must also continue our concerns regarding the capricious and unilateral dictates of the Department of Public Aid and the schizophrenic philosophy of the Department of Registration and Education. And we must continue our sincere and forceful input to modify their *impersonal* and *political* mandates. If we do not, we will continue to witness the insidious encroachment by those who appear to possess minimal understanding of the factors involved with "health care" at the physician-patient level.

To address these problems, a call has been issued by the Board of Trustees on a motion by your President, for a special session of the House of Delegates in Springfield on November 11 and 12.

It is *imperative* that you communicate your views to your delegates and alternates as well as your trustee to ensure that your voice is heard at this meeting.

J. M. Ingalls, M.D.

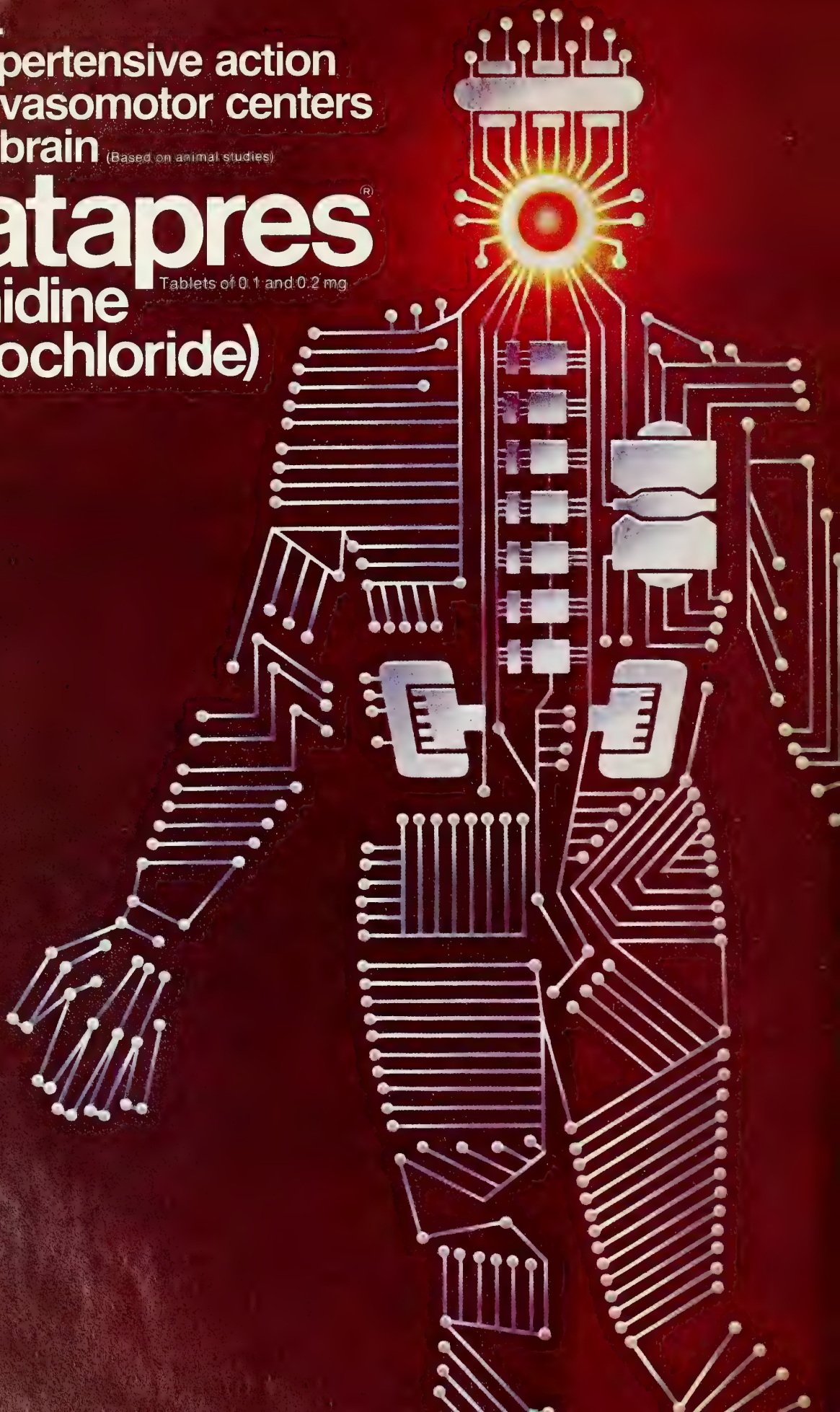
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Tablets of 0.1 and 0.2 mg

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Catapres appears to lower blood pressure through central alpha-adrenergic stimulation, as shown in animal studies. This results in diminution – but not blocking – of sympathetic outflow from cardioaccelerator and vasoconstrictor centers in the medulla.

Not a "depleter", "blocker", "inhibitor" or "false transmitter"

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Mild to moderate potency

The most common side effects are dry mouth, drowsiness and sedation. These generally tend to diminish with continued therapy. Other potential adverse reactions are listed in the Brief Summary.

Catapres® (clonidine hydrochloride)
Tablets of 0.1 mg and 0.2 mg

Indication: The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.
Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres, in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established). These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlorthalidone and papaverine hydrochloride.

Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres (clonidine hydrochloride) overdosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.

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A Century With Aspirin

Almost a century ago in Dundee, Maclagan[1] introduced salicin for the treatment of rheumatic fever. Though today rheumatologists teach and professors of therapeutics preach that salicylates are the sheet anchor of medical treatment of rheumatoid arthritis it appears that in Glasgow at least[2], not every one agrees with this view. Despite invariable initial overenthusiasm (and at times questionably ethical promotion on the B.B.C.) none of the newer antirheumatic drugs are any better than salicylates in stopping progression of joint destruction in severe cases. The very number of available remedies testifies to their individual inadequacy. ("Medical Synovectomy." *Brit. Med. Jl.* (June 29) 1974, pg. 682.)

References

1. Maclagan, T., *Lancet*, 1876, 1, 383, 342, and 910.
2. Lee, P., Ahola, S., Grennan, D., Brooks, P., and Buchanan, W. W., *British Medical Journal*, 1974, 1, 424.
3. *The Times*, February 22, 1974.

Limitations on Medications

In a survey of an institutional geriatric population of 403 patients it was found that among 88 patients who were being maintained with digitalis, 31 had been receiving it for at least a year although currently there was no evidence of heart disease. A study was conducted to ascertain whether or not it was necessary to continue digitalis. Pertinent clinical and laboratory baseline data included serum digoxin levels and creatinine clearance; the remainder of the determinations were repeated three weeks and seven weeks after omission of digitalis. Baseline serum digoxin levels ranged from a trace to 2.7 ng/ml.

Of the 31 patients, 15 (48 per cent) were successfully maintained without digitalis for four months. Because of slight signs of cardiac decompensation, digitalis was started again in the other 16 patients within three to twenty-one days. However, the fact that 48 per cent of the series could be maintained without digitalis indicates the need for periodic re-evaluation under such circumstances. Perhaps the drug was started originally because of transient cardiac stress induced by an acute illness, from which the patient recovered. In such cases, withdrawal of digitalis therapy may prove beneficial. (Harold A. Fonrose, *et al*: "The Efficacy of Digitalis Withdrawal in an Institutional Aged Population." *Jl. Amer. Geriatrics Soc.* (May) 1974, pgs. 208-211).

PROLOID® (thyroglobulin)
Caution: Federal law prohibits dispensing without prescription.
Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.
Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.
The ratio of T_4 and T_3 in Proloid (thyroglobulin) is approximately 2.5 to 1.
Proloid (thyroglobulin) is stable when stored at usual room temperature.
Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.
In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.
Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.
Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.
Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.
Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.
Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.
Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.
Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, $T_3{}^{131}I$ resin sponge uptake, $T_3{}^{131}I$ red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.
Instructions for Use. The following conversion table lists the approximate equivalents of other thyroid preparations to Proloid (thyroglobulin) when changing medication from desiccated thyroid, T_4 (sodium levothyroxine), T_3 (sodium liothyronine), or T_4/T_3 (liotrix).

CONVERSION TABLE

Dose of Proloid (thyroglobulin)	Dose of Desiccated Thyroid	Dose of T_4 (sodium levothyroxine)	Dose of T_3 (sodium liothyronine)	Dose of liotrix (T_4/T_3)
1 grain	1 grain	0.1 mg	25 mcg	#1 (60 mcg/15 mcg)
2 grains	2 grains	0.2 mg	50 mcg	#2 (120 mcg/30 mcg)
3 grains	3 grains	0.3 mg	75 mcg	#3 (180 mcg/45 mcg)
4 grains	4 grains	0.4 mg	100 mcg	
5 grains	5 grains	0.5 mg	125 mcg	

In changing from Thyroid USP to Proloid (thyroglobulin), substitute the equivalent dose of Proloid (thyroglobulin). Each patient may still require fine adjustment of dosage because the equivalents are only estimates.
Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.
(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)
Supplied. ¼ grain tablets in bottles of 100 (N 0047-0250-51) and 1000 (N 0047-0250-60); ½ grain tablets in bottles of 100 (N 0047-0251-51) and 1000 (N 0047-0251-60); scored 1 grain tablets in bottles of 100 (N 0047-0252-51) and 1000 (N 0047-0252-60); 1½ grain tablets in bottles of 100 (N 0047-0253-51) and 1000 (N 0047-0253-60); scored 2 grain tablets in bottles of 100 (N 0047-0257-51); 3 grain tablets in bottles of 100 (N 0047-0254-51) and 1000 (N 0047-0254-60); scored 5 grain tablets in bottles of 100 (N 0047-0255-51) and 1000 (N 0047-0255-60). Full information is available on request. P-GP-51 4/c

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Diabetes Screening Program in Skokie, Illinois*

By Matthew M. Steiner, M.D./Skokie

In a selected population of 28,201 between ages 30 and 59 years, 2601 (9.22%) were screened for diabetes using venous blood glucose determination one hour following a 50 Gm glucose load and preceeded by a 3-day high carbohydrate diet. A level of 160 mg/100 ml or over was considered a "positive screen." There were 2051 (78.85%) with a "negative screen" and 550 (21.14%) with a "positive screen."

Positive screenees (550) were referred to private physicians for standard oral glucose tolerance tests. There were 239 (9.18% of total (2601) screened) reported not diabetic; 90 (3.4%) could not be traced for follow-up; and 221 (8.49%) were newly discovered diabetics. The follow-up of positive screenees was 83.63%.

In newly discovered diabetics, 61.99 percent were males and 38.0 percent were females. Before age 45 years, the incidence of males was 27.14 percent while after 45 years of age it was 72.85 percent.

In the total screened population, overweight occurred in 39.83 percent. In newly discovered diabetics, the incidence was 64.25 percent.

The dramatic increase of diabetes prevalence in the United States constitutes a major health problem in this country.[1-5] The National Health Survey in 1935-1936 estimated that the number of diabetic persons in 1937 was 660,000, approximately 0.37 percent of the population.[6] In 1947, Wilkerson and Krall proposed that 1.7 percent of the population of Oxford, Mass. was diabetic.[7] From a survey in San Jose, Calif. in 1949, a diabetes prevalence of 1.6 percent was reported in an industrial population.[8] In 1965, the Bureau of Census found that there were then 2,385,000 people (1.3%) in the United States in whom a diagnosis of diabetes mellitus had been established.[9] In the metropolitan area of Greater Cleveland, Ohio, an analysis in 1968 of tests for diabetes in 250,000 persons yielded a prevalence rate of 2.1 to 2.8 percent for previously undetected diabetes.[10]

Such estimates vary considerably and methods for detection of the unknown diabetic differ markedly. Many investigators, including the Committee on Public Education and Detection of the American Diabetes Association, are of the opinion that the number of diabetics in this country is grossly underestimated. Based upon a population of 200,000,000, it has been proposed that there are over four million known diabetics, and two million unknown.

The Hidden Diabetic

Finding the unknown or "hidden" diabetic is today's public health challenge, for many people are unaware of the insidious nature of the disease. In contrast to the acute explosive development in juvenile-onset diabetes, many adults have no definite symptoms, are often obese, have not required medical attention and yet when properly examined disclose impaired glucose tolerance. Less frequently, such adult "hidden" diabetics may be unaware of the early signs of diabetes and exhibit cardiovascular or renal degenerative changes, with obesity, hypertension, retinopathy or neuropathy. Included in this group also are the gestational types[11] whose carbohydrate intolerance becomes manifest only

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during pregnancy of women who give birth to unusually large infants[12] and have no other signs or symptoms of diabetes mellitus.

In the fall of 1969, the Village of Skokie Board of Health initiated a pilot program to screen the population between the ages of 30 and 59 years for diabetes mellitus. This segment of the population was designated initially because we felt that reaction to our publicity and education would be favorable and the results of our case finding would uncover a sufficient number of "hidden" diabetics. This program has been expanded as of February 1974 to include all ages in Skokie and in addition, measurements of weight and blood pressure.

TABLE I
Comparison for Age Distribution of 30-59 Year Population in Skokie, State of Illinois and the United States (1970 Census)

	Skokie	Illinois	United States
Total	68,627	11,109,450	203,211,926
Age			
30-34	3,359	634,932	11,430,436
35-39	3,903	612,356	11,108,851
40-44	5,367	659,825	11,980,954
45-49	5,744	668,676	12,115,939
50-54	5,333	626,761	11,104,018
55-59	4,490	509,801	9,973,028
Total	28,201	3,772,351	67,713,226
30-59 % Total Population	41.09	33.9	33.0
Median Age	33.4	28.6	28.1

Statistics

The Village of Skokie is 10.0 square miles in area and about 20 miles north of the Chicago Loop. According to the 1970 Census[13] (Table I) the predominately white population totalled 68,627 with women slightly outnumbering the men; the median age was 33.4 years. This compares with the median age of 28.6 years for Illinois and 28.1 for the United States. Between the ages of 30 and 59 years, the "selected population" chosen for the pilot screening program, there were 28,201 which represented 41.2 percent of the total Skokie population. This compares with 33.9 percent for Illinois and 33.0 percent for the United States. In Skokie, the number of people from birth to 29 years totalled 32,059 (46.71%), and from 60 to 85 years and over, there were 8,367 or 12.9 percent of the total population.

Incidence of Newly Discovered Diabetics

The total population of Skokie between ages 30 and 59 years was 28,201 persons. Of this "selected population," 2601 (9.22 percent) were screened for diabetes mellitus (Table II). Of this screened population, 2051 (78.85 percent) had a negative screen and 550 (21.14 percent) had a positive screen (referred to their private physician for further tests). There were 221 newly discovered diabetics reported to us which represented 40.18 percent of the total positive screen (550) or 8.49 percent of the total number (2601) screened in this program. There were 239 persons with positive screen tests who were referred to their physician but were reported not to have diabetes. This represents 43.45 percent of the total positive screen tests or 9.18 percent of the total (2601) screened population. A relatively small group of 90 persons did not follow-up and return to their physician or could not be traced from the information furnished on their application card. These represented 16.36 percent of the positive screen tests or 3.46 percent of the total screened population. Hence, there was an 83.63 percent follow-up of those with positive screen tests in this program.

Statistics from the Skokie Chamber of Commerce indicated that the yearly income per household was $18,000.00, the median value of homes was $36,713 and the average household was 3.3 persons.

Organization

The diabetes screening program was organized by the Preventable Disease Committee of the Skokie Board of Health following consultation with the Chicago Medical Society and the Diabetes Association of Greater Chicago. The initial screening in December 1969 was for village employees and provided a "dress rehearsal" for the public screening which began in January 1970. Information and brochures were distributed to local physicians, clinics and hospitals outlining the program and setting up procedures and guidelines for follow-up studies and diagnosis. This community wide effort also included local pharmacies, banks, schools, civic groups as well as religious organizations, industrial plants and shopping centers. Publicity was directed via village newsletters, local newspapers, TV spot announcements, auto and bus stickers, store front display cards and street banners.

Skokie residents, ages 30 to 59 years, were asked to call the Skokie Health Department and

pick up instruction sheet, application card, bottle of sweetened drink* and appointment card. Briefly the instruction sheet explained the purpose of the screening test, outlined the high carbohydrate diet to be taken for 3 days prior to the test date, and suggested the withholding of all unnecessary drugs, hormones, contraceptive pills, alcohol, other fluids or food after midnight preceding the test date. People were instructed to ingest the bottle of sweetened drink the morning of the test date and appear at the Board of Health within 45 minutes so that a venous blood sample could be drawn within one hour after drinking the standard amount of glucose.

The application card contained name, address, phone, age, sex, race and weight, family history of diabetes and name of family physician. Persons to be screened were given an appointment for testing consistent with the availability of our technicians and ability to obtain fairly accurate 1-hour post glucose venous samples. The venous blood sample was refrigerated soon after withdrawal and brought to the laboratory within 2 hours. True blood glucose was analyzed by Auto-analyzer(H) (Ferricyanide) method.**

Procedure

In general, the screening procedure of the program consisted of a venous blood glucose sample taken one hour after a 50-gram glucose load and preceded by a 3-day high carbohydrate diet. A screening blood glucose level of 160 mg per 100 ml or over was designated a "Positive Screen." A level of under 160 mg per 100 ml was designated a "Negative Screen." A letter was then sent to all persons screened, whether positive or negative, notifying them only whether they had a positive or negative test. Those persons with "Positive Screen" were advised that the level of their blood glucose was elevated beyond normal limits and were urged to consult their own physician for further testing. This physician was also notified by letter giving the actual blood glucose level in mg per 100 ml together with an enclosure outlining standard methods of oral glucose tolerance tests and diagnostic criteria.[14-15] A report form and self-addressed envelope were also included in the physician's letter to be returned to the Health Department after follow-up testing was done and indicating the type of test performed as well as the results in mg per 100 ml. Follow-up letters and phone calls were made to both positive screenees or their physicians after two months if no reply had been received.[17]

Contains 50 Gms of Dextrose in 10 oz. artificially orange flavored solution (Mutual Newport Bottling Co., Chicago, Illinois).

**The Committee is indebted to Dr. John Gruhn, Pathologist, Skokie Valley Community Hospital, for his cooperation in performing blood glucose tests.*

Results of Screening Program

Persons with known diabetes either by self-admission or by report from the physician were excluded from the data analyzed. Persons with "Positive Screen" and referred to physicians were grouped into three categories, 1) positive screen and negative confirmed (no carbohydrate intolerance after standard oral glucose tolerance test); 2) positive screen and no confirmation (persons did not return to their physicians or could not be reached for follow-up); and 3) positive screen and positive confirmed (these are the unknown or *hidden* diabetics). Finally, all data and results were transferred to punch cards and filed according to age categories (see infra) for future analyses.

TABLE II
Summary of Diabetes Screening Program

Persons	Number	% Total Screened	% Positive Screened
Total Screened	2601		
Negative Screen Test	2051	78.85	
Positive Screen Test	550	21.14	
Positive Screen and Positive Confirmed	221	8.49	40.18
Positive Screen and Negative Confirmed	239	9.18	43.45
Positive Screen No Confirmation or Follow-Up	90	3.46	16.36

Age and Sex

The total selected Skokie population between ages 30 to 59 years amounted to 28,201 of which 13,371 (47.41 percent) were males and 14,830 (52.48 percent) were females (Table III, V). The total population screened was 2601 or 9.22 percent between ages 30 to 59 years. There were 41.86 percent males and 58.13 percent females; the sex distribution compares favorably with that of the total selected Skokie population. In each 5-year age category from 30 to 59 years, about 9 percent of the total for that age category was screened (8.81 to 9.52 percent).

Between the ages of 30 and 59 years, females had more negative screen tests than males—63.67 percent compared to 36.32 percent of the total

TABLE III
Analysis of Screening Program by Age and Sex Compared to Skokie Population

	Skokie Population			Screened Population			
Age	Total	Male	Female	Total	Male	Female	% Total Population
30-34	3,359	1,487	1,872	300	117	183	8.93
35-39	3,903	1,765	2,138	344	135	209	8.81
40-44	5,367	2,451	2,916	511	215	296	9.52
45-49	5,749	2,765	2,984	517	206	311	8.99
50-54	5,333	2,637	2,696	504	228	276	9.45
55-59	4,490	2,266	2,224	425	188	237	9.46
Total	28,201	13,371	14,830	2,601	1,089	1,512	9.22

(2051) negative screen tests. This also holds true in each 5-year age category (Table IV). Between the ages of 30 and 59 years, males had more positive screen tests than females—62.90 percent as compared to 37.09 percent of the total (550) positive screen tests. This also holds true in each 5-year age category.

There were 137 newly discovered diabetics in males between the ages of 30 and 59 years while 84 were in females—61.99 percent compared to 38.0 percent—of the total (221) newly discovered diabetics. Again, in each 5-year age category there were more males than females. Before the age of 45 years (30-44), there were 60 newly discovered diabetics—37 males and 23 females—27.14 percent. However, after the age of 45 years, the number rose to 161—100 males and 61 females—72.85 percent of all the newly discovered diabetics.

Family History of Diabetes

In the total screened population of 2601 persons, there were 1275 persons (49.01 percent) who indicated that there was diabetes in their family (Table VI). This pertained to either parents, maternal and paternal grandparents, maternal and paternal aunts and uncles, sisters, brothers, daughters and sons. For this pilot study we did not analyze the number of close relationships of diabetic family members. In the newly discovered diabetics (221) there were 126 persons (57.01 percent) who gave a family history of diabetes as compared with 48.70 percent in those with a "negative screen" (2051) (Table VI, VII).

Overweight

In the total screened population of 2601 persons, 1036 (39.83 percent) were overweight (Table VI). Individuals were judged to be overweight when they were 15 percent or more above average weight.[18] From ages 30 to 45 years, there was no striking difference between the sexes. However, after the age of 45 years females were heavier than males in this series. The association of overweight with the prevalence of newly discovered diabetics is charted in Table VIII. In the nondiabetics (negative screen), we have excluded 239 persons categorized as positive screen and negative confirmed since we believe that some of these are potential diabetics and will require further testing. There were 730 (35.59 percent) who were overweight and 1321 (64.4 percent) who were not overweight. However, in the 221 newly discovered diabetics, 142 (64.25 percent) were overweight and 79 (35.74 percent) were not overweight.

TABLE IV
Comparison by Age and Sex in Negative and Positive Screen and Positive Confirmed (New Diabetic)

	Male			Female		
Age	Negative Screen	Positive Screen	New Diabetic	Negative Screen	Positive Screen	New Diabetic
30-34	99	20	6	171	10	2
35-39	106	29	10	184	25	5
40-44	152	63	21	260	36	16
45-49	137	69	28	263	48	22
50-54	138	90	36	231	45	21
55-59	113	75	36	197	40	18
Totals	745	346	137	1306	204	84

TABLE V
Analysis of Screening Results by Age Groups in Population Tested

Age	Total Persons Screened	Screening Test Results		Confirmatory Test on Positive Screenees			Confirmatory Positive Tests	
		Negative	Positive	Negative	Positive	Not Done	As % of Total Screening Tests Done	As % of Total Confirmatory Tests
30-34	300	270	30	13	8	9	2.66	38.09
35-39	344	290	54	29	15	10	4.36	34.09
40-44	511	412	99	48	37	14	7.24	43.52
45-49	517	400	117	46	50	21	9.67	52.08
50-54	504	369	135	55	57	23	11.30	50.89
55-59	425	310	115	48	54	13	12.70	52.94
Totals	2,601	2,051	550	239	221	90		

TABLE VI
Incidence of Overweight and Family History of Diabetes in Screened Population

Age	Total No.	Sex		Family History of Diabetes		Overweight	
		Male	Female	Male	Female	Male	Female
30-34	300	117	183	71	116	48	46
35-39	344	135	209	58	125	52	48
40-44	511	215	296	101	180	103	103
45-49	517	206	311	94	135	92	123
50-54	504	228	276	84	142	94	132
55-59	425	188	237	68	101	87	108
Totals	2601	1089	1512	476	799	476	560

Comment

The report of this 4-year pilot program for diabetes screening does not propose to establish definitive statistical correlations concerning diabetes incidence in the general population. Rather, it is a reflection of a unique public health experience in a selected population in Skokie, Illinois, which was accomplished through the efforts and cooperation of the Village Government, the Board of Health and a host of civic organizations. The impact of our continued publicity and lay education to uncover the "hidden" diabetic has been rewarding as we proceed with our expanded program for diabetes detection of all ages within the community.

We were not entirely satisfied with the confirmation tests used by many physicians to whom 239 persons were referred, and who reported to us that they were not diabetic. We believe that there are potential diabetics in this group of positive screen and negative confirmed, and we plan to do standard glucose tolerance tests on all positive screens under our own supervision before they are referred to their physician for definitive care and treatment.

The preponderance of males in the newly discovered diabetics may be a reflection of the limited sample or the 30 to 59 age category chosen for the pilot study. Yet, the greater prevalence of diagnosed diabetes after age 45 years is supported by our data of 27.14 percent newly discovered diabetics before age 45 years and 72.85 percent after age 45 years.

Diabetes was reported in 49.01 percent of the families in a total screened population of 2601 persons. Our publicity campaign did stress, among other factors, the history of diabetes in family members as an incentive for screening. This could have motivated the initial group to cooperate in the pilot program as the number of persons with diabetes in their families appeared surprisingly high.

TABLE VII
Comparison by Age and Family History of Diabetes in Negative and Positive Screenees and Positive Confirmed (New Diabetics)

Age	New Diabetics			Non-Diabetics		
	Positive History	Negative History	% with Positive History	Positive History	Negative History	% with Positive History
30-34	5	3	62.5	165	105	61.11
35-39	6	9	40.0	159	131	54.82
40-44	23	14	62.16	228	184	55.33
45-49	29	21	58.0	179	221	44.75
50-54	34	23	59.64	155	214	42.0
55-59	29	25	53.0	113	197	36.45
Totals	126	95	57.0	999	1052	48.7

TABLE VIII
Comparison by Age and Overweight in New Diabetics and Non-Diabetics

Age	Overweight		Not Overweight	
	New Diabetics	Non-Diabetics	New Diabetics	Non-Diabetics
30-34	6	76	2	194
35-39	12	71	3	219
40-44	26	150	11	262
45-49	32	149	18	251
50-54	34	154	23	215
55-59	32	130	22	180
Totals	142	730	79	1321

We have made no attempt in this report to correlate the post-glucose blood sugar level with the degree of overweight in newly discovered diabetics.[19] While the casual relationship of obesity to the actual development of diabetes mellitus has not been fully clarified, it has been shown[20] that abnormalities in the regulation of fat mobilization may become manifest in nonketotic diabetics only in the presence of obesity. Elevated basal free fatty acids and glycerol, presumably indices of increased basal lipolysis, were found only in diabetic subjects who were also obese. Nevertheless, the incidence of overweight in the total screened population as well as in the newly discovered diabetics augments the necessity for continued education in weight control in the community. ◄

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A complete bibliography for "Diabetes Screening Program" may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe St., Suite 3510, Chicago 60603.

Renal Osteodystrophy— An Unusual Presentation

In a 22 week-old Infant

By Ronald D. Greenwood, M.D. and Howard S. Traisman, M.D./Chicago

Renal osteodystrophy or the systemic metabolic bone consequences of chronic renal insufficiency is well known. The chronic renal insufficiency results in hyperphosphatemia, secondary hyperparathyroidism, chronic metabolic acidosis and decreased intestinal absorption of calcium.[1] *A number of renal diseases can produce this syndrome.*

The following report is of an infant with this entity who presented at a very young age for such advanced disease, and had the unusual clinical picture of seizures with coma, hyperglycemia and glucosuria.

Case Report

A 22-week-old Puerto Rican female was first seen at this hospital with recurrent generalized convulsions over a 5-hour period, and two loose yellow stools about two hours before admission. She had no other known illnesses. This infant was born prematurely after a normal pregnancy by a breech mid-forceps delivery. Birth weight was 1.8 kg (4 lbs) and the baby was kept in the hospital for 20 days for weight gain. There was no family history of seizures, diabetes mellitus or metabolic diseases.

Examination revealed a small female infant with a shrill cry, convulsing with "Moro-like" movements. Pulse was 140 per minute and regular, respirations varied from 50 to 70 per minute. Rectal temperature was 36.5° C (97.6° F); weight was 3.9 kg (8 lbs 11 oz.). The anterior fontanelle was open (1.5 x 2.0 cm) and flat; the eyes deviated to the right with poor reaction to light. Extremities were stiff with bilateral Babinski signs. The liver was palpated at the right costal margin and a functional heart murmur was present. No meningeal signs were present. Otherwise, the physical examination was noncontributory.

Laboratory Studies

Laboratory studies revealed a hemoglobin of 10.9 gm%, WBC 6000/cu mm with 59% polymorphonuclear cells, 38% lymphocytes and 3% monocytes. Urinalysis showed a pH of 5.0, albumin 100 mg%, glucose 1%, sp.gr. 1.008, negative acetone, and occasional red and white blood cell casts. Cerebrospinal fluid obtained by lumbar puncture revealed a glucose of 242 mg%, protein 303 mg% and no cells. A subdural tap revealed 0.5 cc of xanthochronic fluid bilaterally with a glucose of 490 mg% and protein of 125 mg%. Blood glucose was 600 mg%, and dropped to 107 mg% within eight hours without insulin therapy. The BUN was 160 mg%, sodium 144 mEq/L, potassium 5.1 mEq/L, calcium 4.5 mg%, CO_2 of 9.6 mEq/L, chloride 111 mEq/L, phosphorus 14.4 mg% and alkaline phosphatase 17.6 Bodansky Units. Cultures of cerebrospinal fluid, subdural fluid, rectum, blood and throat were negative. Urine culture revealed a mixed growth of *Proteus* and *E.Coli*. Urine ammino acids were normal; urine Sulkowitch was 1+ Roentgenogram of skull, chest and esophagus were normal; the bones were osteoporotic. The electrocardiogram was consistent with severe electrolyte imbalance. The electroencephalogram showed a dysrhythmia suggestive of "mild cortical dysfunction."

Therapy consisted of antibiotics, phenobarbital, calcium and paraldhyde. However, intermittent seizures still occurred. Blood glucose did not rise again, and urine glucose and acetone remained negative. Urine output decreased, the BUN rose to 196 mg%, potassium to 7.5 mEq/L

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and the CO_2 fell to 8.9 mEq/L. Despite attempts at peritoneal dialysis, the baby expired.

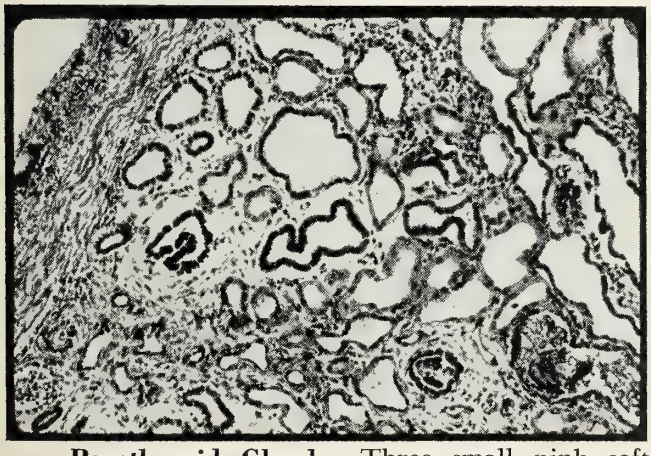
Necropsy Findings

The body was that of a poorly nourished, poorly developed and moderately dehydrated six-month-old child weighing 4.1 kg and measuring 58.4 cm in length, (Normal 62 cm). No gross skeletal deformities were noted.

The most significant findings were present in the kidneys, parathyroid glands and bones.

Kidneys: The right kidney weighed 11 gm and the left kidney 1.5 gm (Normal for age, each 25 gm). Both kidneys were small and fibrous and situated lower than normal with the renal arteries arising from the aorta near its bifurcation. The capsules stripped with difficulty revealing scattered small scars. The cut surface revealed poor demarcation of corticomedullary areas, a thin pale cortex and a reduced number of minor calyces. Microscopic sections of each kidney revealed a distinct decrease in number of glomeruli and focal pitting of the surface without evidence of pyelonephritic scarring. Scattered immature small embryonic tubules lined by columnar cells with hyperchromatic nuclei were seen beneath the capsule and deeper in the cortex. The convoluted tubules showed varying degrees of dilatation and some were filled with pink colloid material.

Only rarely was periglomerular fibrosis noted, however, there was moderate diffuse interstitial fibrosis and focal lymphocytic infiltrates. In one section a small island of cartilage was seen. There was distortion of the corticomedullary junctions and irregular dilatation of collecting tubules which appeared reduced in number (Fig. 1).



Parathyroid Glands: Three small pink soft nodules were found on the posterior aspect of the thyroid. Microscopic sections revealed parathyroid glands composed of closely packed uniform cells with small pyknotic nuclei surrounded by abundant pale watery cytoplasm.

Bones: Microscopic examination of rib and long bone revealed markedly decreased endochondral bone formation with prominent metaphyseal fibrosis and osteoclastic activity. Within the diaphysis thick bands of laminated fibrous tissue surrounded the osseous trabecula. The erythroid and myeloid elements of the bone marrow appeared normal.

Pathologic Diagnosis

1. Bilateral renal hypoplasia and chronic interstitial nephritis.
2. Hyperplasia of parathyroid glands.
3. Renal osteodystrophy.

Contributory terminal events were hyperkalemia and bilateral pulmonary edema.

Comment

This infant's disease resulted from congenital bilateral hypoplastic kidneys with acute and chronic inflammation producing parathyroid hyperplasia, osteitis fibrocystica and osteomalacia. This resulted in acidosis, uremia, hypocalcemia and hyperkalemia. It is unusual to have such profound generalized osteodystrophy at the early age of 22 weeks.[1,2] Generally, the rate of development of osteodystrophy appears to correspond to the age of the patient rather than duration or severity of renal insufficiency.[1]

In addition, the diagnostic dilemma presented by a comatose infant with hyperglycemia and glycosuria is considerable as has been previously noted.[3] The diabetic infant may initially present a picture similar to that of this infant, but great caution must be used in considering insulin therapy in such cases, and only after other causes of hyperglycemia have been excluded.[3] The most likely etiology of the hyperglycemia in this patient was the seizure. To our knowledge, this is the only patient with renal osteodystrophy who presented as an infant with possible diabetes mellitus. ◄

Acknowledgement

We wish to thank James Kidd, M.D. for reviewing the pathological material.

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Improved Mental Health Care Via Satellite

By Donald Fisher, M.D./Arkansas

Satellite mental health centers are an effective means of providing outreach services. They can be established and maintained at a relatively low cost. However, many factors must be considered if such a center is to be viable. Probably the most important is community need and acceptance. It is futile to attempt to provide any service in a community which either does not need it, or for other reasons, is not receptive. It is also important to be able to actually deliver the services offered. Much of the service can, and should come from the community itself, and evaluation of its resource potential must be made wisely. The following series of guidelines are suggested.

Survey of Area

The community must be queried as to its needs, receptivity, and willingness to participate. Direct contact must be made with city officials, community leaders, educators, service organizations, and citizens, including young adults. Support of the city government and the police department is essential, especially if drug abuse is a major concern. Community leaders are usually the best source of knowledge regarding the area's needs. They are often more open, and less frightened than city officials regarding admission of the existence of a local problem, such as alcoholism or drug abuse. Nonetheless, it is worthwhile to talk with many individuals, both young and old, regarding their feelings.

After obtaining area government approval for the establishment of a center, if possible, enlist the personal support of one interested elected official. He can act as a liaison with the city government, give prestige to the undertaking, and provide many community contacts. The establishment of the center may be of political benefit to him, and this is not seen as a deterrent.

Educators are in contact with students and families. School principles are generally respected. They may have liaison staff working directly between the community and schools. If so, this is an excellent way to become acquainted with citizens and their problems.

Service organizations can provide support in several ways, including financially. It is probably best to select one or two organizations which are not already committed to major projects, rather than seek assistance from many service groups.

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Definition and Development

Twelve to eighteen men, women, and young adults should be selected from the area to form a tentative board of directors. Their first order of business should be to decide what services the community needs and should be provided. This is not as simple a determination as it seems. There will be many opinions, especially as to services to be provided. It is important to remember what the probable assets of the community include. For example, it is futile to offer medical services if there are no commitments from physicians for donation of their time. One cannot hope to solve all the community's problems. Realistically, a mental health center must limit its involvement rather strictly, so as to be able to deliver adequate service. The resources of the community as seen through the knowledge of the board must be the limiting factor.

If possible, it is effective to assign specific problems to interested participants. Similar centers in the county should be visited. One of these should be selected as a model, and its functions and structure well learned. The problem of physical plant or housing must be investigated. Other assignments should also be made on a volunteer basis.

After the tentative board has functioned for one or two months, a permanent board should

be selected. A non-profit corporation must then be formed. Information as to pre-incorporation papers such as by-laws and articles of incorporation, can be obtained from other centers. It is also helpful to have an attorney on the board, or have a board member with an attorney as an employee, colleague or close friend, as there is a fair amount of legal work involved in the incorporation procedure.

Resources and Utilization

In the operation of any project, a certain amount of money is required, as are particular services. Commitments for these should be obtained for a pre-determined trial period; otherwise, a good deal of pressure will fall on the developers at an inopportune time. A budget should be carefully worked out, and kept as low as possible. The following are major sources of financing and services.

County: A significant amount of Federal, State, and County money is administered by the County and available for worthwhile projects. This source should be explored early, and as firm a commitment as possible obtained. The County can also be a major source of information and statistical data. It can also provide in-service training for volunteers through related functioning departments.

City: The City will probably have fewer resources available than the County. Nonetheless, it may be able to provide housing on a temporary basis, small donations, location for meetings, remission of fees as for building and use permits, and publicity.

Foundations: Private foundations are a good source of funds, although they are often limited in scope and area. Local librarians can be of help in determining those which would be available for a partciular project. Processing is slow and uncertain, so applications to several foundations should be made.

Service organizations: These include such groups as Kiwanis, Optimist, Chamber of Commerce, and many others. They are interested in their community and can provide money and service. Involvement of such organizations seems to vary. The ideal organization, of course, is one which is active, but not overly commited.

Local business: The business community is always a source of donations, advertising space, and services. For example, printing or other merchandise may be given or obtained at a discount. Credit for such participation should always be given. In a relatively poor community, small donations from many businesses may be more available than large donations from a few. This is in fact desirable, as it gives a broader base of community participation.

Individuals: Donations of money or service from rich or poor is an extensive resource. It may be one of the most difficult to obtain. Service volunteers are plentiful, but must be selectively screened. Many well intentioned persons have difficulty maintaining commitments. Professional volunteers are frequently overly commited, so small demands are more successfully met by them.

Sponsors: Sufficient interest in the project by a significant group can result in sponsorship. In such a case the sponsor may underwrite current expenses, perhaps even future expansion. Such groups are a tremendous asset, and it is useful to always have such an idea in mind.

Staff and Services

Director: The director should be a half to full time person with a multitude of talent, who should be based at the center. Ideally, he should be from the community or the major culture represented. The more qualified he is for an administrative position the better, but the reality of salary available will make compromise necessary. Probably a major part of any governmental grant will have to go toward the director's salary.

Paid professionals: It may be possible to have a professional assigned to the center by the State or County on a part time basis. Since decentralization of service is becoming more the rule than the exception, the State or County may actually be eager to do this.

Professional volunteers: This group should consist of any available combination of psychiatrists, psychologists, and social workers. As was mentioned earlier, it is wiser to ask for a little time from several, rather than a lot of time from a few. Graduate students in psychology or social work may also be available through local universities.

Non-professional volunteers: This group should be the major force or mainstay of the center's staff. They may be persons with previous experience or none at all. Well trained non-professionals are hardly distinguishable from professionals in the mental health center, and should be given responsible duties. Good volunteers are too often lost by professional staff members' failure to utilize their potential.

Affiliations: A multi-service clinic has many advantages. It is most easily developed by asking established agencies to provide limited or part

time representatives to provide service from the center. The needs of their clients in the community, and free access to the center's space and facilities are good inducements. Many agencies are eager to decentralize. Some departments which can be offered space are Employment, Welfare, Probation, and Public Health. Established non-governmental agencies such as Legal Aid Society may also wish to utilize center space. In addition to the direct benefit to the community of having these services closer to it, such affiliates help bring citizens in contact with the more direct mental health services. Familiarity with a mental health center's environment will make it easier to seek its more personal counseling services.

The direct services offered by a community mental health center will depend upon the needs of the community; e.g., family problems, drug abuse, alcoholism, juvenile delinquency, etc., as well as upon the abilities of the available staff. Requests for services are handled either directly by the center or by referral to other agencies. Services provided directly by the center must be limited to those which the staff is confident it can provide adequately.

Operation

The Board of Directors should be responsible for policy and assist the director as necessary. Evaluation of, and adaptation to the changing demands on the center should be handled here. It is desirable that this group meet regularly, perhaps once a month.

The variability of the director's role will depend on his qualifications, services offered by the center, and the availability of other personnel. He may act as therapist, administrator, service coordinator, or all three, especially at the beginning of operation when other personnel will be limited.

Professionals, paid or volunteer, should accept the responsibility for the orientation and training of non-professional volunteers. Continuing in-service training and consultation should be provided.

Non-professional volunteers should organize and maintain an up-to-date community resource file containing information on all agencies which provide human services. A part of the volunteer's training should be to familiarize himself with at least the major agencies which provide for basic needs. Volunteers will need to have this information at hand, as they will also man the telephones and be expected to give accurate information and referrals to appropriate agencies. This volunteer corps should eventually be responsible for most of the counseling which goes on at the center, using professionals for consultation and supervision for the most part.

Conclusion

It is clear that a great deal of volunteer talent is needed for the operation of this type of center. However, a modest beginning can be made with only a few volunteers, who can free the director to recruit professionals, obtain publicity, funds, etc. It is not vital that the center be fully functional from the beginning. A gradual development will give everyone a chance to become acquainted with the operation. It will take several months for the community to become aware of the center and to gradually try its services. Early contacts are especially important to the development of the center's image, so volunteers should be carefully prepared to handle the clients who will contact the center early in its operation.

Beyond the guidelines discussed in this article, the mental health worker interested in establishing a community mental health center can use his own special talents and ingenuity to mobilize the citizens of the community and its resources.

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Parkinson's Disease—A Review

By John L. Bender, M.D./Rockford

In 1817, James Parkinson, an English general practitioner, published a monograph "An Essay on The Shaking Palsy" identifying an entity which was to later bear his name. Six cases were described pointing out an involuntary tremor at rest, which disappeared with volitional movement and was accompanied by weakness. Later investigators came to regard rigidity as one of the features. It has been estimated that about a million persons in the United States are so afflicted.

Principal Features

The principal features of Parkinson's disease are tremor, rigidity, weakness and bradykinesia. Tremor of the pill rolling variety at 3-6 cycles per second with the limb at rest is classical. Tremor stops with voluntary movement, only to return when the limb is again at rest. Resting tremor is an important diagnostic feature of Parkinson's disease, which must be differentiated from the action tremors of heredofamilial, thyroid and cerebellar origin.

Rigidity of the plastic or lead pipe type, in which there is resistance throughout a passive movement, is a feature which helps differentiate Parkinsonism from the clasped-knife rigidity of pyramidal tract lesions. Rigidity helps produce blank expression and monotonous speech pattern. Rigidity makes movement slow and deliberate. There is muscular weakness and easy fatigability with impaired chest expansion and inability to cough. For these reasons, pulmonary infection in the Parkinsonian can be very serious.

Bradykinesia is the involuntary arrest of activity in which a certain body part will unexpectedly and unpredictably freeze in its position for a short period of time. This can occur while one is in the process of performing any coordinated task. The festinating gait with its propulsion or retropulsion is caused by a combination of simian posture, poor balance and bradykinesia. A much more common feature is the bradykinesia which makes it difficult to initiate walking: the patient complains of his feet being glued to the floor. It is related to the marche à petits pas. An even more frequent feature of bradykinesia is the lack of associated movements of the arms when walking. Since the posture of the Parkinsonian is one of flexion dystonia, he is chronically off balance. This, in combination with rigidity and bradykinesia, accounts for his propensity to fall.



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Other Impairments

Although James Parkinson noted "the senses and intellects being uninjured," subsequent investigators have not agreed. The severity of the disorder and underlying personality of the individual combine to produce depressions, hallucinations and paranoid ideation. In 1972, Loranger[1] studied a group of Parkinson patients using the WAIS, concluding that there is a significant loss of intellectual capability, mostly in grasping new material and in memory for recent events. Greasy skin, seborrhea and peripheral vasomotor disturbance are indicative of autonomic nervous system involvement. Although sialorrhea was initially thought to be caused by overproduction, Bateson[2] in 1973, found that defective swallowing was responsible for the drooling and pooling of secretions in the pharynx. This would also explain why atropine-like drugs have been ineffective. Martin[3] in 1973, reported significant sucking, snout and hyperactive jaw reflexes, hemiparesis and Babinski reflexes, in the so-called idiopathic form of the disease. He thought the findings were caused by and should be included in the symptomatology of Parkinson's disease.

The Crises

One cannot describe the clinical signs and symptoms of Parkinson's disease without mentioning the crises. The crises supposedly occur in the postencephalitic type and from phenothiazine administration. The oculogyric crisis is most common with the eyes turned upwards, less frequently downwards or to one side. The pupils are dilated, and the patient is emotionally disturbed. The sweating crisis consists of diaphoresis, tremor, facial flush and elevated blood pressure. The respiratory crisis consists of tachypnea, bradypnea, Cheyne-Stokes respiration, or respiratory

tics which include paroxysmal coughs, yawns, snuffles or hiccups.

Origins

The etiology of Parkinson's disease has been thought to be idiopathic (paralysis agitans) in 60%, post-encephalitic in 33% and all other causes including arteriosclerosis making up the remainder. Kurland[4] in 1958, noted that, although the yearly number of new cases of Parkinson's disease remained the same, those occurring as a sequel to encephalitis were diminishing. However, Poskanzer[5] in 1963, thought that all cases of Parkinson's disease were post-encephalitic. A large group long-term study by Kaplan[6] in 1974, bears out Poskanzer's theory. If this is so, then Parkinson's disease will be a rare occurrence by 1990. This then brings us to the history of epidemic encephalitis resulting in Parkinson's disease. The first recorded epidemic was noted by Sydenham in London (1673) and since then, epidemics have been noted in Germany in 1712, in Italy in 1846, and in Northern Italy in 1890. There were epidemics in Vienna and in England in 1917, and in Glasgow, Scotland, in 1928. The Russians claim that encephalitis lethargica is endemic to the Lake Baikal region of Siberia. It has been conjectured that the pandemic of World War I came about through transfer of troops from this region to the Balkans.

Von Economo from his observations of the Vienna epidemic was first to classify the various manifestations of encephalitis lethargica: a somnolent-ophthalmoplegic variety with lethargy, headache, fever, vomiting and meningismus, which progressed to coma with eye muscle palsies; a hyperkinetic form with delirium, hallucinations, sleep reversals, myoclonus and chorea; an akinetic form which passed into Parkinson's disease with coma, delirium, dementia and insomnia. Von Economo's encephalitis resulted in death in a third to one-half. In those who survived, there could either be complete recovery or partial recovery with muscular wasting, mental retardation, psychiatric disturbance or Parkinsons disease. Children were often left with character disturbance, which expressed itself in violent or amoral behavior.[7]

Parkinson's syndrome has been reported to occur in Jakob-Creutzfeldt disease, in the Shy-Drager syndrome and as part of the Parkinsonian-dementia-amyotrophic lateral sclerosis disease of the Guamanians. The Westphal variant of childhood Huntington's Chorea presents as juvenile Parkinsonism. Brait, in 1973,[8] published four cases of whom three developed Parkinsonism followed later by motor neuron disease. The 4th case had features of Parkinsonism, motor neuron disease and ataxia. Normal pressure hydrocephalus producing a Parkinsonian-dementia syndrome with clearing of the symptoms after shunting was reported by Sypert.[9] Familial Parkinsonism, including juvenile cases, has been reported. One study indicates that the mode of inheritance would have to involve more than one gene.[10] Less frequent causes of Parkinson's syndrome are carbon monoxide, syphilis and Behcet's disease. Iatrogenic Parkinson's syndrome from rauwolfia alkaloids and phenothiazines rarely continues to persist after withdrawing the offending agent. Chronic exposure to manganese dust[11] will produce a Parkinson's syndrome which is unaffected by levodopa and only temporarily abates with the chelating agent EDTA. Manganese produced changes in the lenticular nucleus and liver similar to Wilson's disease.

The Pathology of Parkinson's Disease

I will just brush over the pathology lightly in noting that the disorder seems to fall heaviest on the globus pallidus and substantia nigra. The cerebral cortex, striatum, subthalamic nucleus of Luys, red nucleus, inferior olivary nucleus and reticular formation have all been implicated to lesser degrees.

Drug Therapy

Charcot in 1874, was the first to administer belladonna alkaloids to Parkinson patients. In 1945, the synthetic alkaloids were introduced and in most instances have been replaced by levodopa.

In our present state of knowledge, the major biochemical defect of Parkinson's disease appears to be abnormally low brain dopamine. (Fig. 1) The chemical configuration of dopa is such that it can pass through the blood-brain barrier, while peripheral dopamine cannot. Only the levo form of dopa is therapeutically effective in the Parkinsonian. The organs of the body peripheral to the nervous system convert levodopa to dopamine with peripheral dopa decarboxylase so efficiently that only 1% of the ingested levodopa ever penetrates the blood-brain barrier. Sufficient brain dopamine can only be obtained by ingesting large quantities of levodopa.

Levodopa has alleviated the akinesia, rigidity and speech defects[14] with little or no clinical improvement of tremor. The large doses of levodopa have produced severe nausea and vomiting, vascular hypotension with syncope, cardiac arrhy-

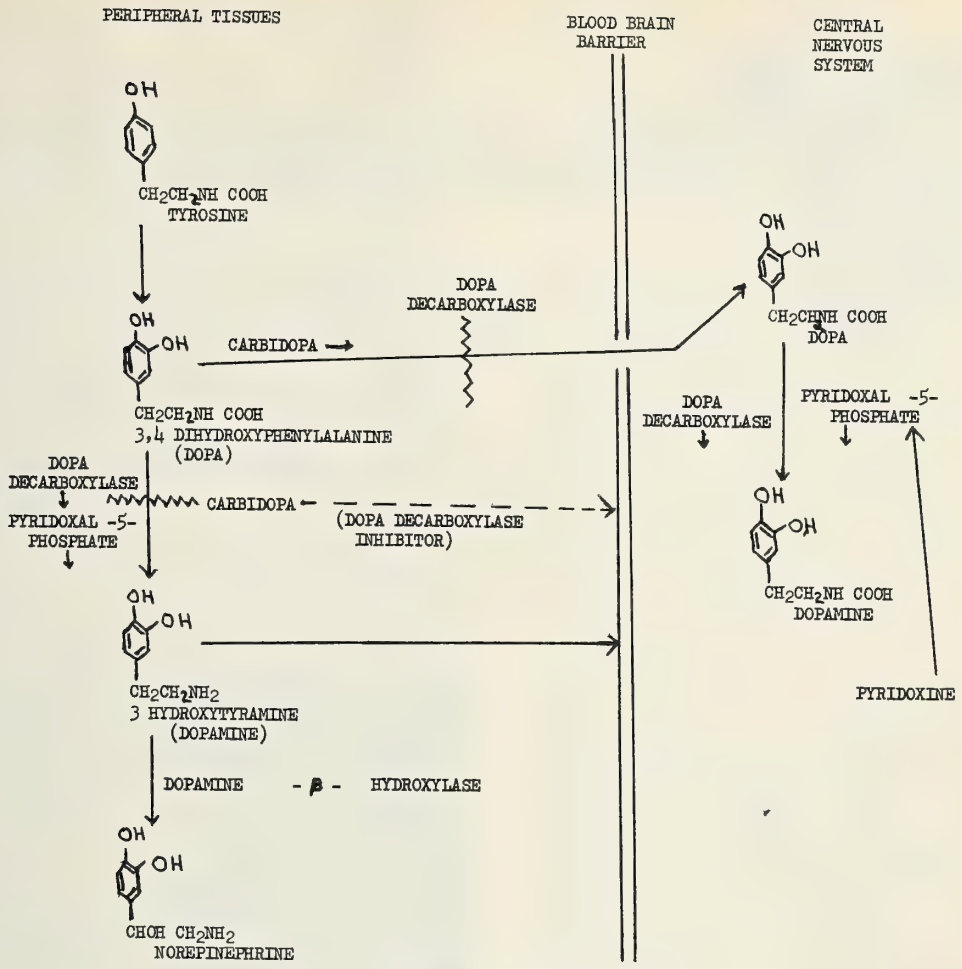


Fig. 1. The Metabolism of DOPA

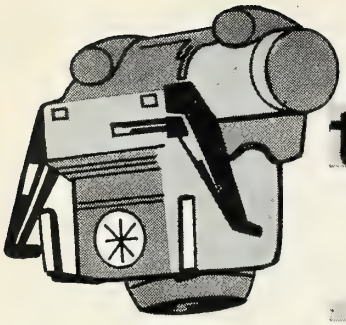
thmia, increased libido, hemolysis and jaundice, conversion of the Coombs and ANA tests, and mental changes including prolonged somnolence, disorientation and delirium. Dementia has been reported with the use of levodopa.[15] Too large a dose will produce an overshoot with choreoathetotic dyskinesias. Levodopa administration has been known to adversely affect pigmented nevi and is contraindicated in patients who have had melanomas.[16] Pyridoxine antagonizes levodopa by accelerating its metabolism through activation of peripheral systemic dopa decarboxylase.

Carbidopa, a dopa decarboxylase inhibitor, prevents the conversion of levodopa to dopamine in the periphery. Carbidopa does not pass the blood-brain barrier. It allows a greater amount of levodopa to pass unchanged through the body into the brain, where nervous system dopa decarboxylase converts it into the needed dopamine. Giving Carbidopa with levodopa in a one to ten ratio reduced by 80% the required amount of levodopa needed to attain therapeutic levels and successfully prevented nausea, vomiting and vascular hypotension. The only major side effect was choreoathetosis.[18] Some patients who have now been on levodopa for two or more years have been experiencing what has been referred to as akinesia paradoxica or the "on-off" phenomena. This consists of a sudden loss of ability to move, lasting minutes to hours with just as quick return of mobility. Use of carbidopa and levodopa have had no effect.[19]

Recent investigation has tended to correlate dopa levels in a given patient with this effect, relatively higher levels being found during the "on" mobile times than during the "off" akinetic times. The authors were able to help a few of their patients by giving a 10 gram protein diet on the supposition that this would decrease the amount of competing amino acids available in the stomach for absorption.[20] Barbeau[21] has recently found evidence of a generalized body dopamine defect in Parkinson patients.

A recent study by Martin and Baker[12] indi-

(Continued on page 231)



the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

Herniated Thoracic Intervertebral Disc

By Behrooz Azar-Kia, M.D., F.R.C.R. and Enrique Palacios, M.D./Maywood

Symptomatic thoracic intervertebral disc disease is rare, occurring more frequently in the lower dorsal region.[1-3] *The prognosis of this disease, with or without surgical intervention, is not as good as when it occurs in the lumbar and cervical regions.*[2] *We are presenting a case of thoracic extradural lesion which, at surgery, proved to be a herniated rupture intervertebral disc.*

Case Report

A 27-year-old, right handed female, was admitted with chief complaint of difficulty in walking with "drunk-like" staggering of 7 months duration. Her symptoms seemed to be aggravated during her menses, becoming somewhat worse at night. In addition she complained of some numbness in her left toes for approximately the last 8 months. She denied any change in bowel or bladder function. No weakness or sensory changes in the upper extremities were elicited. There was a history of head trauma at the age of 14 developing grand mal seizures which have been under control with dilantin. Neurological examination revealed spastic hemiparesis mainly of the left leg. Deep tendon reflexes were increased in both upper and lower extremities. There were bilateral unsustained clonus. There was also noted upgoing toe sign on the left. Examination of the cranial nerves were all intact.

Plain films of the entire spine showed no definite abnormalities. A pantopaque myelogram revealed a large extradural mass lesion at the level of T_9 causing almost complete blockage to the flow of contrast medium at this level (Figs. A and B).

Computerized tomography of the head appeared normal. Thoracic laminectomy with intradural exploration was performed and several pieces of white material were removed along with osteophytes at the level of T_8 and T_9. Pathologically these proved to be fragments of fibro-cartilage, consistent with intervertebral disc.

Post operatively she developed a myelopathy at the level of T_8 with paraparesis and brown-sequard like syndrome. The patient was discharged to a rehabilitation center.



Figure 1A. Anterior posterior view of thoracic myelogram demonstrates an extradural defect causing almost complete block and also displacement of the spinal cord to the right.



Figure 1B. Lateral view of thoracic myelogram showing an ovoid defect opposite to T_8-T_9 intervertebral disc space.

Comment

Thoracic disc disease is uncommon; however, this entity should be kept in mind in order to make a specific diagnosis.

Plain films of the thoracic spine for the most part are of little aid in the diagnosis of herniated disc. Calcification and narrowing of the intervertebral disc space and presence of osteophytes are non-specific changes. Myelography is the only way to delineate the extradural defect of the herniated disc. It must be stressed that large amounts of pantopaque (20-40 cc.) should be used for better delineation of suspected lesions in the thoracic region, provided there are no signs of spinal block.[1-4] The patient also should be examined in supine position, if necessary, for a thorough evaluation of the thoracic canal. If obstruction to the flow of the contrast medium has characteristics of extradural defect with its maximum width anteriorly, adjacent to the intervertebral disc space, the diagnosis of thoracic disc herniation should be considered. However, such extradural defect could be seen laterally or dorsally with complete or partial blockage simulating other types of extradural lesions such as metastatic disease. ◄

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Parkinson's Disease

(Continued from page 229)

cates that trihexyphenidyl HCl (Artane) given in combination with levodopa is no better than levodopa and a placebo. However, the addition of Amantadine HCl (Symmetrel) to levodopa can be used as effective adjunctive therapy.[13] Alpha methyl dopa had been used to propagate the effects of levodopa but vascular hypotension and syncope frequently occur. One should also note that an exercise program is helpful.

Use of Surgery

Surgery consists of a stereotactic placement of a lesion in the thalamus (thalamotomy.) Mechanically placed lesions were first, and electrically produced lesions followed. Now cryosurgery using liquid nitrogen is being used. Surgery has been effective in stopping tremor and reducing rigidity, but is ineffective against akinesia. The small size of the structures involved and the proximity of the internal capsule to the site of lesion can produce either temporary or permanent hemiparesis. Bilateral thalamotomy has produced dysarthric speech which may or may not respond to levodopa. To the internist and neurologist, the most important aspect is the selection of the candidate. The ideal candidate fills the following criteria:

1) 50 years of age.
2) Parkinsonian signs are limited to one side of the body and consist primarily of tremor.
3) No complicating disease processes such as cardiac disease.
4) No history of psychiatric breakdown or dementia.
5) The patient has not responded to drug therapy.

Summary

In summary, although there has been considerable advance in the treatment of Parkinson's disease, our knowledge of this disorder and ability to successfully treat it is far from complete. ◄

Reference

A complete bibliography for Parkinson's Disease—A Review may be obtained by writing the *Illinois Medical Journal,* 55 E. Monroe St., Suite 3510, Chicago 60603.

The Echocardiogram of Primary Pulmonary Hypertension

By Joseph G. Ellis, M.D. and Herbert P. Friedman, M.D./Urbana

Echocardiography corroborated a clinical impression of primary pulmonary hypertension in an illness that ended in death. The autopsy confirmed the accuracy of the echocardiographic patterns.

Cardiac catheterization and angiography are dangerous procedures in patients with primary pulmonary hypertension.[1] It would be preferable to confirm the diagnosis of this untreatable disease by safer methods. Mitral stenosis may mimic some aspects of primary pulmonary hypertension and should be excluded with certainty. An echocardiogram can achieve both these goals by demonstrating characteristic patterns of pulmonic valve motion and right and left heart chamber dimension in primary pulmonary hypertension, while at the same time showing the type of mitral valve motion which excludes mitral stenosis.

Case Report

A 17-year-old white girl suddenly collapsed at school after running up a flight of stairs. She was unconscious, but revived within several minutes. During the next few months she became increasingly short of breath on exertion and began having anterior chest pains. She again fainted without warning, this time while walking. She had noticed swelling in her feet and experienced occasional vomiting. Her birth, growth and development had been normal although she remained small and avoided exertion. She had been examined a number of times during infancy and childhood, but a heart murmur was not heard until a year before the syncopal spells occurred.

The young woman was not cyanotic nor were her fingers clubbed. Her blood pressure was 100/80 mm. Hg. While she was in the upright position, neck veins pulsed to the angle of her jaw. The systolic heave of the pulmonary artery was palpable in the second intercostal space to the left of the sternum. There was a right ventricular heave and gallop sound and an ejection click, but no systolic murmur could be heard over the pulmonary artery. There was a diastolic murmur of pulmonic insufficiency and, lower, a systolic murmur of tricuspid insufficiency. The second heart sound in the pulmonic area was closely split and the second component was accentuated.

The patient's chest X-ray was abnormal. The heart shadow was large; the main pulmonary artery shadow was enlarged and the distal pulmonary artery shadows were small. The aorta was small. There was a pattern of severe right ventricular hypertrophy and strain apparent on the electrocardiogram. PO_2 breathing room air was 80 mm. Hg. The oxygen saturation was 96%. The hematocrit was 45%. The clinical diagnosis was primary pulmonary hypertension.

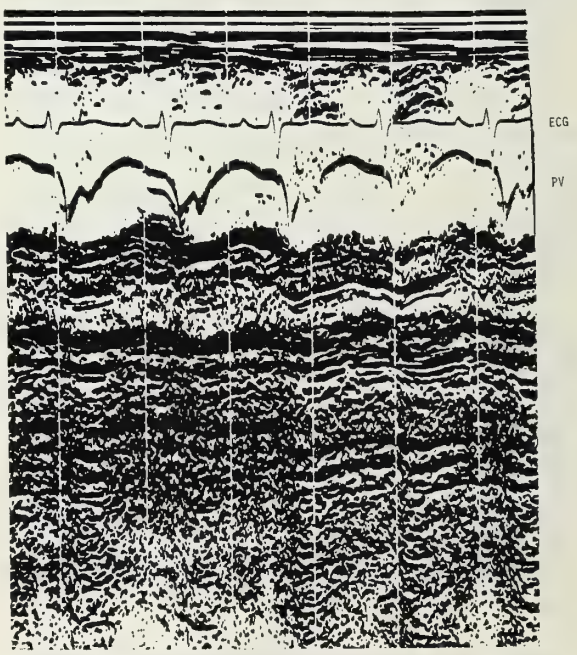


Figure 1. Echocardiographic motion of the pulmonic valve. The posteriorly moving cusp closes prematurely in systole then opens again producing a "W" on the moving record. The mirror image shape of the anteriorly moving cusp is faintly outlined by a few echoes in the third beat. The presystolic portion of valve motion is flattened.

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HERBERT P. FRIEDMAN, M.D., is a Pathologist and Director of Laboratories at Carle Clinic and Carle Foundation School of Medical Technology. He is also a Clinical Associate at Illinois School of Basic Medical Sciences and Associate Staff at Eastern Illinois University and Illinois State University. As well he has been a Laboratory Inspector and Blood Bank Inspector and is a member of many medical societies.

The Echocardiogram

An echocardiogram outlined a large, thick right ventricle, stunted motion of the mitral valve, a small left ventricle with slow, shallow contraction of the posterior wall, and a small pericardial effusion. The movement of the pulmonic valve could be recorded (Figs. 1-3). The pulmonic valve is difficult to record by echogram in normal individuals, but not in patients with primary pulmonary hypertension. This disease enlarges the main pulmonary artery and pulmonic valve echoes usually hove into view by placing the transducer over the spot on the chest wall where systolic swelling and closure tap are maximum. In this case, the pulmonic valve motion reflected pulmonary hypertension.[2-4]

Presystolic motion of the valve was flattened and the rapid opening movement was followed by premature closure (Fig. 1). A close look at the mitral valve echoes (Fig. 2) showed these features: in diastole, the anterior leaflet of the mitral valve crowded against the interventricular septum reducing its closing velocity; normal separation of the posterior leaflet dispelled any suspicion of stenotic disease.[5,6] In systole, the posterior leaflet bulged backward toward the left atrium, not necessarily indicating an abnormality of the valve, but suggesting it was too large for the ventricle. The echocardiogram, recorded from a beam path through the right ventricle, its papillary muscle, the interventricular septum and the left ventricle, contrasted best the large right ventricle with the hypoplastic left ventricle. (Fig. 3).

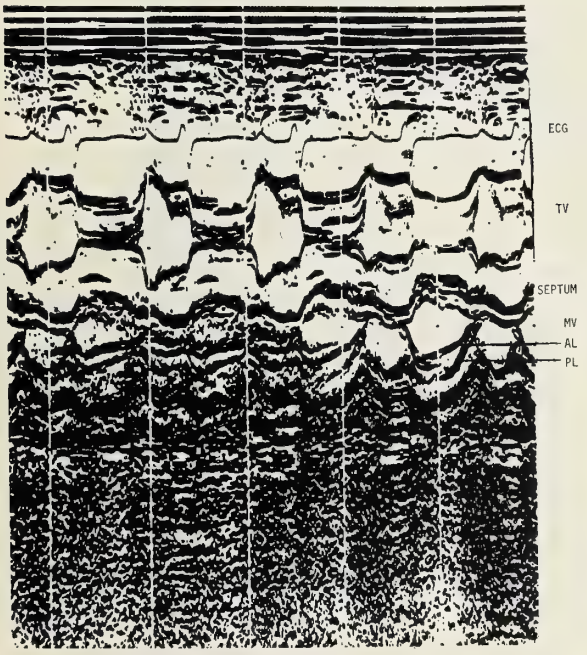


Figure 2. Echocardiogram from a beam path through the right ventricle, interventricular septum, and left ventricular-left atrial junction. The right ventricle is large, permitting a clear view of the motion of several cusps of the tricuspid valve (TV). The septum is the next structure and beneath it moves the mitral valve (MV). Anterior (AL) and posterior (PL) leaflets of the mitral valve can only be identified in the last two beats. During systole, the posterior leaflet bows posteriorly, indicating prolapse. During diastole, the anterior leaflet contacts the septum and lies plastered against it until valve closure. Meanwhile, the posterior leaflet separates from the anterior leaflet at the onset of diastole and moves posteriorly in a normal manner, ruling out mitral stenosis.

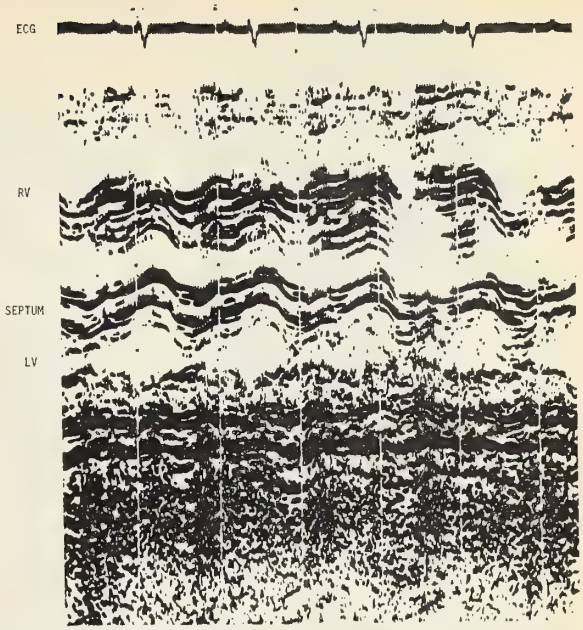


Figure 3. Echocardiogram recorded through a lower part of the right ventricle, interventricular septum and left ventricle. This level corresponds to the transversely cut heart of figure 4. In the middle of the right ventricle, bands of echoes reflect from the thickened papillary muscle. Beyond the septum lies the left ventricle. It is small and wall motion is stunted and flat. Separation between epicardial and pericardial echoes represents a small pericardial effusion.

Eight months after the onset of syncopal spells and after progressive right heart failure this patient died. The echocardiograms were recorded ten weeks (Fig. 3) and three weeks (Figs. 1,2) prior to death.

Autopsy Findings

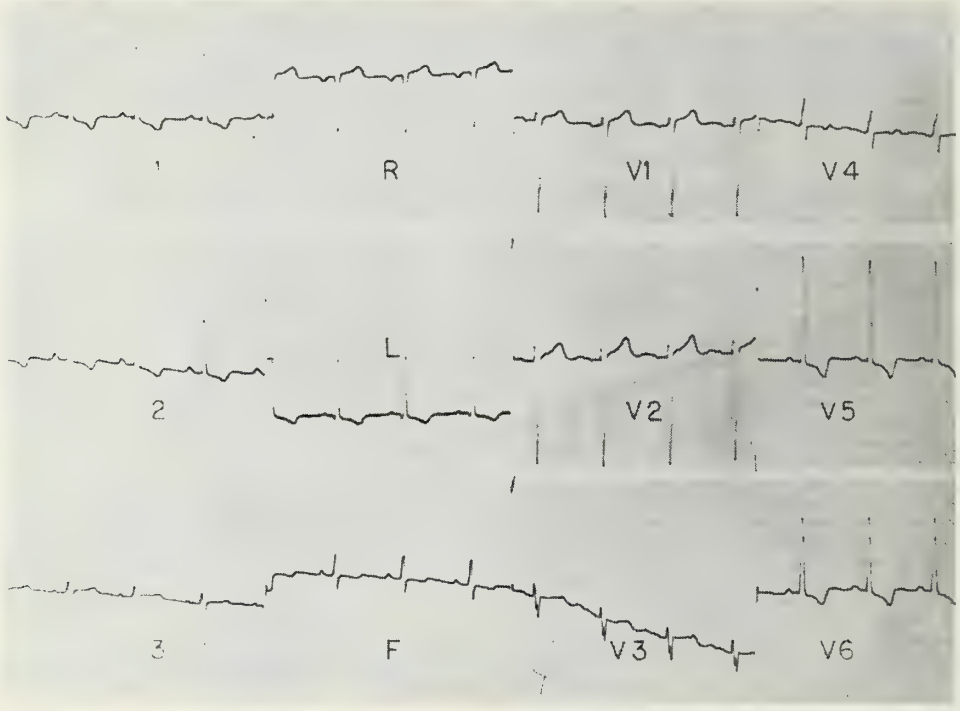
At autopsy, smallness of the left ventricle, left atrium and aorta was confirmed. The mitral valve was normal. There was right ventricular hypertrophy. The pulmonary arterial tree was dilated and lined by atherosclerotic plaques. The small muscular arteries showed medial hypertrophy and some of these had intimal plaques as well. The alveolar septae were thin and there was no evidence of fibrosis, thrombi or other anatomical lesion which might account for pulmonary hypertension. Pulmonary veins were normal. A

(Continued on page 253)

ekg of the month

John R. Tobin, Jr., M.S., M.D., Rimgaudas Nemickas, M.D., Patrick J. Scanlon, M.D., John F. Moran, M.S., M.D., Sarah Johnson, M.D., and Rolf M. Gunnar, M.S., M.D./
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A 45-year-old black man presented for evaluation of a random blood pressure recording of 180/115 mmHg. This was confirmed by three further measurements on three different days of blood pressure recordings ranging from 160 to 180 over 115 mmHg. The patient had a long history of borderline high or labile hypertension. His family history was positive in that his father had died suddenly at age 52 years of a myocardial infarction. His physical examination demonstrated cardiomegaly which was confirmed by a chest X-ray. A hemogram, urinalysis, serum electrolytes, cholesterol, triglycerides, BUN, and 2 hour post prandial blood glucose were ordered. The electrocardiogram is shown:



Questions:

1. The ECG shows:
- A. Complete left bundle branch block.
- B. Anterior wall myocardial infarction.
- C. Right ventricular hypertrophy.
- D. Left ventricular hypertrophy.
- E. Abnormal left axis deviation.

2. The purposes of a diagnostic evaluation of hypertensive patient (is) are:
- A. To search for curable causes of hypertension which, if corrected, would eliminate lifelong therapy.
- B. To identify other coronary risk factors.
- C. To identify any other co-existing disease which might affect prognosis or alter the patient's treatment.
- D. To determine the severity of hypertension and the presence of end organ damage, eg. heart, brain, eye, kidney.
- E. All of the above.

(Answers on page 239)

Medical Direction in Long-Term Care Facilities*

By Bertram B. Moss, M.D./Springfield

Skilled-Long-Term-Nursing-Care Facilities are required to have a Medical Director on a part time or full time basis prior to January, 1976. Before that date, the Administrator must indicate in writing that the Skilled Nursing Care Facility meets the intent and content of the Regulations applying to compliance, which means much more than just having a written agreement with a physician. A new philosophy for the medical profession in dealing with residents of long-term care facilities is now required. Health, not disease, must be the orientation, and this is the reason for this concept as it relates to elderly residents of the facility. The primary goal of intervention is now the promotion and support of the physical, psychological, and social functions and capacities of the aging individual. Intervention on the part of the physician and his allied professional colleagues now aims at the prevention of break down and the restoration of the aging individual to his highest potential. The secondary goal, which was all too often the primary goal formerly, is that of crisis intervention and treatment addressed to a particular disease or disability in a specific individual. This new professional goal, now the responsibility of the Medical Director, will produce institutional change and broaden the responsibilities and accountability of the medical profession in relationship to the functioning of long-term care facilities in meeting the needs of the elderly residents.

Utilization Control

The concept of medical direction initiated in skilled long-term nursing care facilities is part of the new program of Utilitation Control. Utilization Control has a much broader meaning with respect to institutional services than the more familar term of Utilization Review. The Utilization Control regulations are compatible with, and supportive of, HEW's Professional Standards Review Organization (PSRO) and will permit an orderly transition to the operation of PSRO. Implementing the provisions of the 1972 Social Security Amendments (concurrently being contested legally), the new regulations establish similar review systems for both Medicare and Medicaid for the first time. The new medical director concept legislated into reality results from the frustration of attempts to produce numbers of physicians willing to practice geriatric medicine.

A Skilled Nursing Facility is defined as an institution primarily engaged in providing to inpatients (a) skilled nursing care and related services for patients who require medical or nursing care, or (b) rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

An Intermediate Care Facility is an institution licensed under State law to provide, on a regular basis, *health-related* care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing home is designed to provide, but who because of their mental or physical condition require care and services, above the level of room and board, which can be made available to them only through institutional facilities.

The primary difference between a skilled nursing facility and an intermediate care facility is in the *kind* of services provided with respect to the skill and frequency involved and the supervision that the patient requires.

Requirements of a Geriatrician

The basic personal requirement for a Medical Director in a Skilled Care Facility is that the doctor must enjoy working with elderly persons. This includes understanding that oftentimes such work is conducted with patients who are involuntary of stool and incontinent of urine and not bathed as frequently as one would like. This work in-

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*Presented April 1, 1975 in Chicago to a Seminar titled, "A Practical Look at Medical Direction in Long-Term Care Facilities," sponsored by the ILLINOIS STATE MEDICAL SOCIETY, in conjunction with the AMERICAN MEDICAL ASSOCIATION.

volves dealing with persons who soon forget what you tell them, who have to have everything repeated and explained to their families, and are usually frightened, confused, extremely anxious, and mostly poor.

Geriatricians have to test their professional skills with old people who have a multiplicity of illness, a proliferation of various physical and psychological deficiencies, paradoxical and reciprocal reactions to medications, little patience and no hope for the future. Geriatricians have to modify their teachings of preventive health measures when dealing with the elderly, their established goals of rehabilitation, their definitions of cure, and their distaste of working with government regulations and requirements.

Geriatricians serving a long-term care facility learn the motivations and intent of those associated with such facilities. The physician has to attest to the physical and mental status of employees, and be responsible for the environmental health situation in the entire long-term care facility. He must be astute and alert to filter out those persons who work in such facilities primarily to be in command of those less fortunate than themselves. These are the ones who express such terrible masochistic and cruel treatment to unsuspecting residents.

Other Requirements

The Medical Director must be familiar with governmental laws and regulations, sympathetic to their intent and understanding of the goals of public health. The Medical Director of a long-term care facility must be one who can work closely with paraprofessionals. Many of the services provided to the residents will emanate from the nursing staff, the many therapists and the counselors. Paraprofessional services are often of much greater importance to residents than the medical care and medical restrictions offered by the Medical Director.

The Medical Director of a facility must understand the patient's rights, the rights of families of residents, and the rights of all who serve the elderly. The Medical Director must be able to work comfortably with patients who are functionally incompetent, both professionally and legally.

Geriatricians must understand and deal with the many myths, misconceptions and negatives of old age—the loneliness, penury problems, idleness, illness, rejection, abandonment, mourning, self-deprecation and loss of hope. Medical Directors have to deal not only with the many elderly patients who *don't* want to be in the institution, but their children who sometimes *do* want them to be there. We are not forgetting the case workers, the third party who financially supports the elderly, the occasional institutional staff who may be exploiting, abusing or neglecting them, and most of society in general who do not wish to deal with the problem of aging and death. Geriatricians are always called upon to give more and more of the commodity most physicians claim they have the least of—*time!*

The Medical Director has to deal with those who are soon to die, and palliate those who are overdue in dying. He must be the advocate and the protector of the elderly from the unscrupulous, the meddlesome, and the ignorant who prey on the elderly. The Medical Director is now legally responsible for good quality care in the facility and publicly accountable. The Administrator can seek haven from public accountability by claiming to follow the orders of the owner. The owners can hide if they own only a partial interest in the home, or in all cases by just not revealing the books and records of the facility.

Demand for Quality Care

The demands of public accountability for providing quality care and services for our institutionalized elderly must be equally shared by owners, administrators and professionals providing the care. Legislators and regulatory agencies must face the challenge of immediate attack on the most serious aspects of quality medical care that can be modified. We should be attacking hidden ownership and secret financial records to acquire public accountability. We should take measures to avoid the need for expensive and wasteful defensive medicine. We should be doing something about faulty results from poor training, greed, and avarice, as causes for poor quality care. We should avoid futile and repetitive pressures to attempt cure of those diseases of the aged for which we do not as yet have a cure. On the other hand, we should deplore neglect, abandonment and under-utilization, as much as over-utilization.

Our immediate concern should be for all professionals dealing with the elderly to learn about the aged we are dedicated to serve. We need to understand the current theories of aging, the pathology of aging, the process of aging, and what is normal aging. We must understand the wishes of the elderly as well as the effects of medications upon them, and the attitude of society and the elderly to the aging process. We must

convince everyone concerned with providing quality care that to use outcome measurements to evaluate quality seems unreasonable, since most illnesses are self-limiting, and particularly with the elderly, no effective intervention is possible for many conditions. Immediate attention to specific problem areas that can be improved (drug reaction, neglect, abandonment, abuse, inactivity, etc.) has a much greater chance of yielding social benefits than to attempt to improve the broad range of problems of the elderly with which we have not as yet learned how to deal.

Utilization Review Committees

The Social Rehabilitation Service is still waiting for the HEW General Counsel's office to give a legal interpretation of the term "employee" as it relates to one serving on a UR Committee. The Guidelines now being issued forbid membership on a UR Committee to one employed by the facility or by any facility of the same level of care. Hospitals are not under such a prohibition. Also awaiting legal definition with HEW are bans against performing UR by one with a financial interest in a facility, and one with direct responsibility for patient care. Another vague provision is that of prohibiting an employee from performing UR in the same type of facility.

A definitive ruling has not been handed down as to whether non-physician personnel on UR Committees have full voting privileges. The entire question of voting privileges on UR has not been clarified. Physician members of Utilization Review Committees are required to develop criteria, norms, and standards which non-physicians as professional personnel must utilize in their admission and continued state reviews. The regulations stipulate that adverse decisions require the concurrence of two physician members of the URC, unless the attending physician fails to present his views, or does not contest the decision, in which case one physician member of URC may make the final determination.

The regulations indicate that reviews may not be conducted by any person who was professionally involved in the care of the patients being reviewed. In effect, this ruling requires that skilled nursing care facilities have a third physician to serve on the UR committee as an alternate for one of the two physicians whose patient is being reviewed. Professional involvement means direct patient care involvement. The attending physician and the nurses rendering direct care would be considered as professionally involved, but the director of nurses would not be barred from UR activities because of her non-direct involvement. The question of associated clinic physicians reviewing another clinic physician's patients has also not been answered.

If the skilled long-term care facility has an organized medical staff, the medical director is designated by the medical staff with approval of the governing body. A medical director may be designated for a single facility or multiple facilities through arrangements with a group of physicians, a local medical society, a hospital medical staff, or through another similar arrangement. To the extent that the regulation requires any skilled nursing facility to engage the services of a medical director either part or full time, the Secretary may waive this requirement for such periods as he deems appropriate if, based upon documented findings of the state agency, he determines that:

(1) Such facility is located in an area where the supply of physicians is not sufficient to permit compliance with this requirement without seriously reducing the availability of physician services within the area, and

(2) Such facility has made and continues to make a good faith effort to comply with the regulation but such compliance is impeded by the unavailability of physicians in the area.

Patient Care Policies

Each nursing facility (skilled or intermediate levels) must have written Patient Care Policies to govern the continuing skilled nursing care and related medical or other services provided as part of the new program of Utilization Control. The facility must have policies developed by the medical director or the organized medical staff with the advice of (and with provision for review of such policies from time to time, but at least annually by) a group of professional personnel including one or more physicians and one or more registered nurses, to govern the nursing care and related medical or other services it provides. The policies, which are available to admitting physicians, sponsoring agencies, patients, and the public, reflect awareness of, and provision for, meeting the total medical and psychosocial needs of patients, including admission, transfer, and discharge planning; and the range of services available to patients, including frequency of physician visits by each category of patients admitted. These policies include provisions to protect patients' personal and property rights. Medical records and min-

utes of staff and committee meetings reflect that patient care is being rendered in accordance with the written patient care policies, and that utilization review committee recommendations regarding the policies are reviewed and necessary steps taken to insure compliance.

The medical director or a registered nurse is designated in writing to be responsible for the execution of patient care policies. If the responsibility for day-to-day execution of patient care policies has been delegated to a registered nurse, the medical director serves as the advisory physician from whom she receives medical guidance.

Medical Direction and Administration

Medical direction and coordination of medical care in the facility are provided by a medical director. The medical director is responsible for the development of written bylaws, rules, and regulations which are approved by the governing body and include delineation of the responsibilities of attending physicians. Coordination of medical care includes liaison with attending physicians to ensure they are writing orders promptly upon admission of a patient and periodic evaluation of the adequacy and appropriateness of health professional and supportive staff and services.

The administrator, not the medical director, ensures that established patient care policies are effectively implemented. The administrator develops the terms of the written agreement consummated with the medical director, and evaluates and implements recommendations received from the medical staff and submitted through the medical director. Inasmuch as the administrator manages the ongoing functions of the facility on a daily basis, he must provide the kind of support essential for the medical director to function effectively within the facility. The medical director will be responsible for carrying out his responsibilities under the written agreement. The terms of the agreement should specify, as a minimum, the responsibilities of both the facility and the medical director, a description of the types of service to be provided, the delineation of lines of communication, the amount of time to be given, the financial arrangements, duration of the agreement, and provision for periodic review of the agreement.

Duties of the Medical Director

If the facility has an organized medical staff, the medical director's primary function is to serve as liaison officer between administration and the medical staff. The medical director coordinates medical care, maintains effective liaison with attending physicians, implements methods to keep the quality of care under constant surveillance, participates in the development of written policies, rules and regulations to govern skilled nursing care and related medical and health services and assures their effective implementation. In addition, the medical regimen is incorporated in each patient care plan. The medical director participates in staff and committee meetings and implements methods that assure continuous review of employee health status.

The medical director must be aware of any attending physician's delinquency in making prescribed and appropriate patient visits. He should notify the administrator of such delinquency and himself take needed steps to correct non-compliance with the regulations, including informal notification of, and consultation with, the delinquent attending physician. If informal action has not been successful in obtaining timely visits, the administrator should put the delinquent physician on notice by formally notifying him in writing of the facility's policy concerning patient supervision, the facts of the delinquency and action the facility will take if the failure to provide timely visits continues. The administrator should maintain a record of action taken and efforts made to obtain compliance with patient supervision policies by attending physicians.

If an attending physician requests and justifies that an alternate schedule of patient visits is desirable, the medical director should review such requests and advise the administrator and the utilization review committee as to the adequacy of the justification. If the utilization review committee or the medical review team concurs, the administrator notifies the appropriate state agency of the alternate schedule of visits.

All of the above steps may still fail to achieve the desired outcome of appropriate and timely physician services to all patients in the facility. The medical director, with concurrence from the governing body, may find it advisable to develop a program of physician education and surveillance through the local and/or state medical society. The recent contract with the AMA provides a vehicle for the establishment of an ongoing system of education and technical assistance designed to improve the quality of physician services in long-term-care facilities. As these programs develop, the provider facility should be encouraged to contact and work with appropriate state or local medical society committees to obtain needed assistance.

Schedule of Physician Visits

If a private patient is classified as a patient in need of skilled or intermediate levels of nurs-

ing or rehabilitative care, the attending physician must provide physician services in keeping with the facility's policies for that category. If the patient does not need skilled nursing or rehabilitative services, the policies for care at another more appropriate level of care would apply. In Illinois, non-medical and non-nursing care is provided for residents residing in licensed facilities called sheltered care facilities. SCF's provide personal care, and general oversight for residents institutionalized for dependent social reasons.

Patient supervision by physicians in SCF's and ICF's requires (405.1123 (d) (i) that the facility have a policy that the health care of every patient be under the supervision of a physician, including the provision that the patient in need of skilled nursing or rehabilitative services be seen once every 30 days for the first 90 days following admission. Subsequent to the 90th day following admission, an alternative schedule up to 60 days between visits may be justified by the physician when in his opinion visits at 30 day intervals are not necessary. Such justification must be reviewed and approved by the UR Committee and/or medical review team. In addition, if the patient is a Medicaid recipient, the state Medicaid agency must be notified of the change in schedule. This alternate schedule does not apply to patients who require specialized rehabilitative services, in which case the review must continue to be done at least every 30 days. ICF patients need to be recertified every 60 days.

All long-term care facilities must therefore have established written policies that are applicable to all patients cared for in the facility, including private patients. In the case of private patients, the attending physician must indicate the level of care needed by his patient on admission and at the time of any subsequent review and revision of the patient's care plan, whether at the SNF, ICF or other (e.g. domicilliary) level of care. For whatever level he designates, the policies regarding physician visits and supervision will apply. In the provision of supervision to private patients, the attending physician must maintain the same appropriate standard of care as for those paid for under Medicare and/or Medicaid. As further support of this policy, it shuold be noted that many private patients, when their source of support is no longer available, become Medicaid patients.

Conclusion

In conclusion, the medical director is now responsible and accountable for medical direction of care and services in skilled nursing facilities. The incentives for such awesome charges have not been provided. We await, with grave trepidation, the response of the medical profession. Authority, responsibility, and accountability for performance of difficult, serious, and life threatening duties without incentive and support for accomplishment are difficult to achieve.

Experience has demonstrated that facades of medical care, warehousing of the unwanted elderly, the sick, and the dying, solely for profit, cannot be ameliorated by government regulation. A society that permits poor quality medical care, and excessive profits in lieu of really providing the best for the elders, and tolerates concealed ownership and hidden financial statements will not solve the dilemma. Periodic muckraking and investigatory public exposes of the villains only accomplishes temporary social catharsis through the mechanism of ventilating anger and frustration. The solution lies in encouraging and providing incentive to well intended physicians, administrators, and owners of long-term-care facilities. We need a combination of the intents and motivations of the non-profit facilities with managerial systems and skills of profit makers.

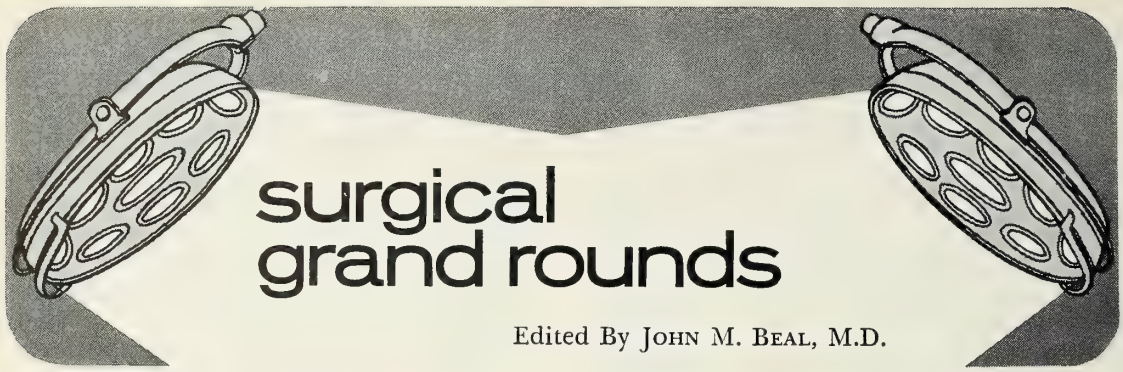
The future for provision of high quality care and service to residents of long-term-care facilities is rapidly improving. The Federal government has sparked the flame and their insistence should soon motivate state regulatory agencies to develop and enforce even higher standards, rules and regulations. ◄

EKG

(Continued from page 234)

Answers: 1. D. 2. E.

The ECG shows left ventricular hypertrophy by several voltage criteria, eg. the sum of SV_1 + RV_5 is greater than 35 mm, the sum of R lead I + S lead III is greater than 25 mm, and the R in V_5 is greater than 26 mm. In addition there are ST-T wave changes in leads I, II, avL, V_5 and V_6 in the absence of digitalis that are commonly called "the strain pattern." The QRS axis in this case is not leftward being approximately +10°. Hypertension may be the most important public health problem in the United States, affecting 20 to 25 million people. A history and physical examination with the lab tests listed above will suffice in evaluating most patients. More extensive testing is usually reserved for those patients whose blood pressure cannot be controlled readily with medication. Both the Veteran's Administration cooperative study and the Framingham study detailed the morbidity of hypertension.



Edited By John M. Beal, M.D.

Surgical Grand Rounds are held weekly on Tuesdays at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of February 26, 1974.

Duodenal Ulcer in Childhood

Dr. Heidi Rothenberg: A nine-year-old white boy was admitted to Children's Memorial Hospital January 21, 1974, with abdominal pain and history of a duodenal ulcer since age 4½ years. In infancy, his mother reports that he "spit up" his feedings and was a "colicky baby." At age 4 he had a tonsillectomy, there was a fire in the house, his sister broke her leg, his parents dumped all four children on a babysitter and left for Florida on a vacation and this particular child vomited every day and complained of abdominal pain. He did not have a history of diarrhea, hematemesis or melena. Investigation included X-rays of the stomach and duodenum which demonstrated a duodenal ulcer. He was treated with milk and a bland diet and his parents were counseled. The child did fairly well but vomited every three to four months. Occasionally he took maalox. He drank a gallon of milk a day, but occasionally complained of epigastric burning, until December 24, 1973. At this time he was admitted to another hospital with a ten day history of melena. He complained of epigastric pain and had been vomiting clear material four days. His temperature was 101° F. At the time of admission, hemoglobin was 6 gm. and hematocrit was 17. A transfusion of 1000 cc of whole blood was given. Upper gastrointestinal X-rays were reported to demonstrate two active duodenal ulcers. He remained in the hospital for two weeks and was discharged to take antacids and phenobarbital. After a week at home, vomiting and diarrhea began again, and he was referred to Children's Memorial Hospital.

Additional History

He is the oldest of four siblings, and is said to be a good student. His father is a salesman, runs a greenhouse, manages a Little League team and also has a duodenal ulcer which was diagnosed four years ago. The father has one brother and two sisters with duodenal ulcers and his father had an ulcer. The mother is a swimming coach, spends three to four hours a week on tennis lessons and is very active socially. The children are frequently left at home alone with a babysitter. The parents tend to argue with each other and they were arguing with each other while the history was being taken.

Physical Examination

Temperature 99° F., blood pressure 104/68, respirations 16. Positive findings were limited to the abdomen. The abdomen was somewhat distended in the epigastric area and peristaltic waves were visible. The epigastric area was tympanitic percussion. Bowel sounds were active but masses, guarding and tenderness were absent.

An upper gastrointestinal radiologic study showed a deformed bulb and an enlarged stomach which was slow to empty (Fig. 1 and 2) Evidence of an active ulceration was absent. Nasogastric drainage was instituted and the volume of drainage ranged from 15 to 120 cc an hour. A 24 hour gastric analysis had a total volume of 920 cc with free hydrochloric acid 47.5 mEq and total 65.2 mEq. He was seen by a psychiatric consultant who described him as a rigid, compulsive, perfectionistic personality and sug-



Figure 1. Upper gastrointestinal X-rays demonstrated duodenal ulcer crater.

gested counselling and therapy. With a diagnosis of functional obstruction secondary to duodenal ulcer, he was discharged on 1/28/74 to receive additional conservative therapy. Two weeks later he continued to have "hunger pains." Abdominal physical examination continued to detect upper abdominal distension and peristaltic waves. He was evaluated as a possible candidate for surgery.

Dr. John Raffensperger: It isn't often that we have an opportunity to decide on an elective operation for a peptic ulcer in children. Most of the ulcers that we have seen in children result from stress. Ulcers can almost be characterized on the basis of age. In the neonatal period, ulcers may develop in babies who have been hypoxic and are manifested by perforation or hemorrhage. Children also develop ulcers with perforation or hemorrhage who have brain tumors, subdural hematomas and other types of central nerve system disease. Some are secondary to burns. A smaller group of children form ulcers while receiving steroid therapy.

It is in the young teenager that one begins to find the usual adult pattern of peptic ulcer. I treated a boy who perforated his ulcer the night before he graduated from high school. Another young patient was from the southern part of the state. He was so tense that he drank a pint of whiskey a day, smoked a pack of cigarettes, and developed a standard ulcer. When I listened to the story of the boy presented today, I was absolutely aghast over the amount of stress that this family imposes on this boy. It came out in curious ways. He was said to be the best little league player and his father said that's all he wants to do in the Spring. This sounded logical and reasonable, but then it was learned that the father ran the Little League. So, what else could the poor kid do but go out and play baseball. I spent several hours trying to get the family to re-organize themselves. I have been concerned that even if we treated his ulcer successfully, other manifestations of tension would appear unless the family situation was corrected.

This boy has had very good medical therapy. He has had naso-gastric decompression, later hourly antacid therapy and a very rigid diet. Despite well regulated conservative management, he still has visible peristaltic waves and a succussion splash. He is still getting up at night to drink milk for pain relief. He appears to have cicatricial pyloric obstruction. What would be the best operation for this boy? Most of our definitive operations for ulcers are for hemorrhage. One general approach has been to perform pyloroplasty, ligate the bleeding operation and then do a bilateral truncal vagotomy. This has been successful in the control of hemorrhage and in the treatment of the ulcer. However, some of the children that have had truncal vagotomies are troubled with diarrhea. I invite your comments on selective vagotomy.

Dr. John Beal: Dr. Hines, would you like to comment? I know you have devised a special type of pyloroplasty.

Dr. James Hines: The youngest that I have operated upon have been teenagers over the age of 15 years. I have not had experience with selective vagotomy but have continued to perform a



Figure 2. Delayed films show slow gastric emptying and marked deformity of duodenal bulb.

truncal vagotomy. We now have a series of 70 patients with vagotomy and double pyloroplasty without ulcer recurrence. They do occasionally have diarrhea and mild dumping.

Dr. John Raffensperger: At one time it was said that vagotomy and pyloroplasty would interfer with growth in a child. However, it is apparent now that neither vagotomy and pyloroplasty nor gastric resection interferes with growth. We can eliminate that objection but I am concerned about some of the other side effects of vagotomy.

Dr. John Beal: Peptic ulcer is an uncommon problem in infancy and childhood and operation is not undertaken frequently. Koop of Philadelphia reported his experience in 1970. There were 27 children with duodenal ulcers between the ages of 15 days and 15 years and most of these were boys. As pointed out by Dr. Raffensperger, bleeding was more common in the younger children and pain in the older children. Among the 27 patients, a precipitating cause could be identified in 15. There was a central nervous system lesion in 5, severe emotional problems in 5, steroid therapy in 3, congenital heart disease in 1 and a neurological problem in another. Thus, only 12 children were left who had duodenal ulcers without specific cause. Only six of these children were treated surgically, emphasizing that ulcers heal by conservative means in most children. Operation is saved for the serious complications.

To comment on your question, whenever the function of the pylorus is destroyed by incision or removal, the patient is likely to develop postprandial disturbances. These are somewhat less severe than the patients who have pyloroplasty rather than resection. In adults, there has been little difference in the side effects with truncal vagotomy and with selective vagotomy. Selective vagotomy involves denervation of the stomach, leaving the celiac branch intact to the pancreas and small intestine and the hepatic branch to the gallbladder and liver. Selective vagotomy has been found to achieve complete gastric vagotomy in a higher percentage of patients than truncal vagotomy. We have been very pleased with this operation. This child will require some type of drainage procedure because he is partially obstructed and because of the duodenal ulcer, vagotomy is indicated. Parietal cell vagotomy requires unimpaired emptying of the stomach and is not appropriate in this problem. We had one failure with parietal cell vagotomy where the patient did have impaired emptying of the stomach but it wasn't apparent until after operation. He had to have a pyloroplasty later.

The child that was presented today has failed to respond to conservative treatment. Operation is required because he has chronic duodenal ulcer with evidence of obstruction. You are interested in selecting the operation that carries the least risk, that is vagotomy and drainage. This provides good protection against recurrent ulcer.

Addendum

Operation was performed on March 20, 1974. A large duodenal ulcer was found with a marked inflammatory reaction and cicatricial stenosis of the pylorus. A selective vagotomy and antrectomy was performed. A Billroth II anastomosis was required because of the reaction at the site of transection of the duodenum.

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2. Raffensperger, J. G., Condon, J. B. and Greengard, J.: "Complications of gastric and duodenal ulcers in infancy and childhood;" *Surg. Gynec. & Obst.*, 123:1269, 1966.

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The Development of a Public Education Program for an EMS System

By David S. Forkosh, M.D., F.A.C.P. and Captain Carol A. Bryant/Chicago

The Chicago North Side Commission on Health Planning (CNSCHP) developed one of the first areawide EMS plans in Illinois. One of the aspects of that plan which has not been covered in a status report has been the development of the Public Education Program. The Areawide Committee learned certain important facts which we felt would be applicable to all areawide plans and developed a methodology for the development of an ongoing areawide public education program.[1]

EMS Pamphlet

The first public education implement that was utilized by the Areawide Committee was a trilingual (English, Spanish and Greek) pamphlet describing the services available at various comprehensive and basic hospitals. The pamphlet has been cited in other publications.[2] This pamphlet had as its primary concept a "go, no-go" concept, i.e. it told patients where to go for emergency care.

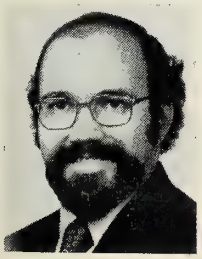
This pamphlet, which was distributed via the Boy Scouts to as many residences as possible on the North Side of Chicago, was designed to be hung on a doorknob. The pamphlet informed the population that certain things should be done in the case of an emergency. First, the family doctor should be called; secondly, other steps which could be taken to contact absent parents, etc. A space for the family doctor's telephone number was provided on the pamphlet. Finally, if assistance could not be gained from usual resources, the people were instructed to go to the closest of the listed emergency departments. Hospitals with basic and comprehensive emergency departments were listed alphabetically, with addresses and locations listed by Chicago's grid system. No telephone numbers were included. On the inside of the pamphlet, an explanation of the areawide plan was given in three languages, and other cooperating hospitals were listed. The reverse of the pamphlet carried the same text as the front but in Spanish.

This pamphlet, which was widely distributed, is presently available in all this area's hospitals and in some of the clinics and doctors' office buildings. It has been relatively successful in alerting the population to the existence of a new areawide emergency medical service system but offers no in-depth education.

Speakers Bureau

The EMS Committee felt that the development of a Speakers Bureau was essential to approach service groups, schools, churches, women's organizations, etc., with a program which would explain the purpose of the areawide system and give the general population a chance for further education in the use of the system. In order to accomplish this goal, certain standards had to be met. First presentations had to be available in all applicable languages for the community. Second presentations should be the same in all groups. Third presentations should be done in terms easily understandable to the layman. And finally, the presenter must be sufficiently educated about the system to answer questions from the floor with ease.

In order to accomplish these goals, the Areawide Public Education Committee, in cooperation with the Department of Emergency Medical Services, developed a slide show and speech. The group of people who wrote the speech quickly discovered that consumer input into the speech was extremely important. Professionals in the health care field tend to speak a language all their own. Because of the audience for which these presentations are intended, consumer input is essential to keep the program on a level acceptable to those various groups who will see the program.



DAVID S. FORKOSH, M.D., F.A.C.P. is Medical Director of the Sydney R. Forkosh Memorial Hospital, Chicago. He is also Chairman of the Areawide Emergency Medical Services Committee of the Chicago North Side Commission on Health Planning and a member of the Metropolitan Emergency Medical Services Commission appointed by the Chicago Board of Health.

CAPTAIN CAROL A. BRYANT is an Officer of the Salvation Army and Administrator of Booth Memorial Hospital, Chicago. She is Chairman of the Public Education Subcommittee of the Chicago North Side Commission on Health Planning.

The cooperation of our Areawide Committee and the Department of Emergency Medical Services gave great impetus to the development of a standard slide presentation which explained the Statewide Trauma Program and also developed a script which was sufficiently flexible so that local or regional solutions to particular problems could be included in the program. For example, slides of local hospitals can be inserted when one is describing a comprehensive or basic department. When showing an ambulance which meets the Department of Transportation's standards, a local ambulance company's equipment should be used.

Development of the Speakers Bureau

After the speech and slides were prepared, it was important to develop a reliable group of speakers. We chose to seek volunteers who would speak to community groups from within the local hospitals. Each hospital gave a list of two to three speakers. Interested citizens should also be encouraged to participate.

The Committee

The speech was distributed in a training program before the Speakers Bureau began. At first it was felt that the student speakers would feel more at ease giving the presentation in the hospitals where they worked. However, this supposition was totally incorrect. We found that the student speakers felt more at ease in another hospital. The Administrators at various hospitals arranged for the student speakers to give their presentations to various groups of hospital employees. Two things were accomplished. The speakers were trained and many interesting points were raised by hospital employees. The input from hospital employees assisted us in modifying the presentation to some degree and also gave us a more comprehensive list of the type of questions which a lay population might ask. Given these questions, standard answers were prepared and given to the speakers so that they were able to answer in a uniform way.

Finally, after having trained a Speakers Bureau which has the capability of delivering the program in English, Spanish and Greek, we had to find audiences for the speakers. This final problem was solved by having Administrators of various hospitals submit lists of their community organizations. The Areawide Committee contacted these groups to set up times which were appropriate for presentations by our Speakers Bureau.

Prior to each practice presentation and each actual presentation, a questionnaire was placed on the chairs of the audience. The questionnaire provided space for the audience to answer questions about their own knowledge of emergency medical services before and after the presentation. This allows the Speakers Bureau to assess its effectiveness and make modifications in areas where it would appear necessary.

Conclusion

This article has attempted to describe the approach taken by the CNSCHP in implementing the requirement for areawide education about emergency medical services. The impact of this education has not been fully monitored. Hopefully, the approach we followed will be of use to other areawide committees throughout the state. ◄

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2. Ford, J. D., "Planning depends on analysis of capabilities," *Journal of the American Hospital Association,* May 16, 1973.

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Information concerning numerous other continuation courses available upon request.

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Doctor's News

SPECIAL MEETING OF THE HOUSE OF DELEGATES OF ISMS slated for November 11 and 12 at the Forum Thirty Plaza in Springfield. The Board of Trustees has called this meeting to determine the course of action to be taken by the Society in:

1. Professional liability legislative proposals and other related matters.
2. The relationship with state regulatory agencies, including factors affecting the availability and quality of medical care and the development of adequate mechanisms for negotiation.

PSRO DESIGNATED FOR AREA IV FOR THE STATE OF ILLINOIS—On May 14, 1975 the Secretary of HEW announced intention to enter into an agreement with the Quad River Foundation for Medical Care, designating it as the Professional Standards Review Organization for PSRO Area IV located in Illinois. As not more than 10% of the doctors engaged in active practice in PSRO Area IV have expressed timely objection to entering such agreement, the Secretary has entered this agreement.

CHRIST HOSPITAL TO SPONSOR TRAUMA DAY—Christ Hospital of Evangelical Hospital Association will sponsor its second annual "Trauma Day" on Wednesday, October 1. The day-long program is intended to inform emergency health care personnel about current concepts in the cooperative approach to emergency medical treatment being developed by the Illinois Emergency Medical Service System. "Trauma Day," coordinated by Dr. Julius Brant, director of ambulatory services, will begin at 9:00 a.m. It will be held in the classrooms of Evangelical School of Nursing, located on the Christ Hospital campus at 9345 S. Kilbourn Ave., Oak Lawn.

ICCME TO HOST TWO WORKSHOPS THIS FALL—The Illinois Council on Continuing Medical Education will present two weekend workshops in October and November marking the start of a series of weekend workshops on CME Planning. Designed primarily for Hospital DME's, Program Chairmen, Medical Faculty and other CME Planners, the first is titled "Introduction to CME Technique" and the second, "Identifying CME Needs Through Medical Audit."

The first workshop is scheduled for the weekend of October 24-26 at the Oak Brook Hyatt House, Oak Brook, Ill. It will offer an introduction to effective methods for planning and conducting in-hospital CME, training in group technique for problem-solving and an analysis of the learning needs of hospitals or other medical organizations. The second workshop, also at the Oak Brook Hyatt House, is scheduled for the weekend of November 21-23. The workshop will focus on how to formulate criteria for quality of care and use those criteria to identify learning needs. For further information about both workshops, including faculty, AMA Category 1 credit, registration fee, etc., write or call The Illinois Council on Continuing Medical Education, 55 East Monroe, Chicago, Illinois, 60603. (312) 236-6110.

EMIT SYSTEM TO BE INSTALLED—The Illinois Dangerous Drugs Commission, in order to maximize the accessibility, reliability, and utility of its toxicology services for urine screening, will be installing in several locations throughout the state on-site testing equipment known as the EMIT system. The Dangerous Drugs Commission will provide the equipment and pay for the cost of its use. However, any clinic who wishes to use the on-site testing equipment must provide its own staff time to run the tests. In order to determine at what location to place such a system, interest in participation must be determined. Write to: Dangerous Drugs Co nmission, 300 N. State St., Suite 1500, Chicago, 60610.

ILLINOIS PSYCHIATRIC SOCIETY WILL HOLD SECOND ANNUAL FALL WEEKEND MEETING, September 26-28, 1975, at the O'Hare Marriott. Co-ordinated by Drs. Francois E. Alouf, IPS President; Alex J. Spadoni, President-Elect; and Anne M. Seiden, Program Chairman, the three-day program will feature in-depth workshops, paper presentations and film seminars on a variety of subjects. The keynote speaker at the Saturday, September 27, 1975, banquet will be Dr. Melvin Sabshin, Medical Director of the American Psychiatric Association. For further information, please contact the Society's offices at 263-7391.

REP. PHILIP M. CRANE TO BE KEYNOTE SPEAKER at the Illinois Society of Internal Medicine Annual Meeting, October 10, 1975. The meeting, held in conjunction with the Illinois regional meeting of the American College of Physicians, will be held at the Drake Hotel (Chicago). For further information, please contact the Society's offices at 263-7150.

PHYSICIANS IN THE NEWS—New officers of the Chicago Gynecological Society for 1975-76 are President, **Lester D. Odell, M.D.**; President-elect, **Ralph M. Wynn, M.D.**; Vice President, **Michael Newton, M.D.**; Secretary, **Robert E. Lane, M.D.**; Asst. Secretary, **John C. Buckingham, M.D.**; and Treasurer, **Philip C. Williams, M.D.**

The election of new officers of Thorek Medical Center staff has also been announced. They are: President, **Bashir Khan, M.D.**; 1st Vice President, **Evangelos Georgoulis, M.D.**; 2nd Vice President, **George Procopie, M.D.**; 3rd Vice President, **Tarsicio Morales, M.D.**; Secretary, **Stanton Polin, M.D.**; and Treasurer, **David Goldfinger, M.D.**

Dr. Marshall A. Falk, Dean of the Chicago Medical School has announced the appointment of **Dr. Edward Tyler** as Associate Dean for Students. Eight new Department chairmen have also been named. They are **Joseph W. Linhart, M.D.**, Department of Medicine; **Julian Berman, M.D.**, Department of Pediatrics; **William Schumer, M.D.**, Department of Surgery; **Uwe E. Freese, M.D.**, Department of Obstetrics-Gynecology; **Lawrence L. Hirsch, M.D.**, Department of Family Medicine; **Reuben C. Balagot, M.D.**, Department of Anesthesiology; **Donald F. Pochyly, M.D.**, Department of Health Sciences Education; and **Arthur S. Schneider, M.D.**, Department of Pathology.


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585

Administration of In-Line Filters

A final report to the USP Committee on Large Parenterals, based on results of a study on I.V. fluid filters at the University of Kentucky, entitled "The Double-Blind Study to Evaluate the Function of an In-Line Filter and Determine the Effects of Buffering and Frequent Changing of the Administration Set," has been made.

Based on the results of this study, the following recommendations are made:

1. An in-line filter should be added to the administration system for routine intravenous infusion therapy.
2. In-line I.V. filters of a 0.22 micron pore size and sufficient surface area and possessing features to eliminate air should be developed and evaluated.
3. Until such ideal filters are available, existing filters should be used for no longer than a 24 hour period of time, and educational programs be developed for their proper utilization.
4. Investigations should be conducted to assess the clinical significance of the microcrystalline and amorphous residues present in antibiotic products routinely added to infusions.
5. Extreme caution should be exercised in the buffering of infusion fluids to which antibiotics are to be added.
6. Addition of additives to an intravenous administration system should be through a particulate retentive filter.

Excerpted from "News" of the United States Pharmacopeial Convention, Inc.

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Guest Editorial

When was the Last Time You Considered Running for the Legislature?

Probably never, and that's one of medicine's problems. We physicians have been so totally involved in the important work we do that we frequently ignore the important work others are doing in fields that directly affect us. Government, and its necessary companion, politics certainly falls in this category.

Malpractice . . . PSRO . . . Medicare . . .Medicaid . . . HSA . . .

One would think that with the ever growing impact of government on the profession that physicians would be clamoring to get more involved in this crucial new facet of medicine. And yet, when ISMS schedules a Washington Roundup for face to face meetings with Illinois Congressmen, only 100-125 physicians and spouses regularly attend. At the height of the battle for passage of the ISMS malpractice bill in the last session of the Legislature, only 400 physicians and spouses bothered to attend this critical one day rally. And, most incredible of all, in this day of ever growing government, less than half of the physicians in Illinois belong to medicine's political action arm, IMPAC.

Have you ever attended a Washington Roundup? Were you in Springfield last May to work on the malpractice bill? Are you and your spouse members of IMPAC? If the answer to any of these questions is no, then you're not doing your fair share of the work. Politics affects us all, so how can we expect our partner to carry the whole load any more than we could expect him to see all our patients or do all our surgery? We can't.

ISMS employs a governmental affairs staff that can help you get involved in a meaningful way. And, if the headline in this editorial really piqued your interest, they can also advise you on running for the legislature. There are currently no M.D.'s or spouses in the Illinois General Assembly. Interestingly enough, there is an optometrist, a chiropractor, a dentist and 3 pharmacists, all of whom maintain a private practice in addition to their legislative duties.

Now is the time for Illinois medicine to be on the move, and all of us have a responsibility to help. Act today. Contact the ISMS Governmental Affairs Division, 55 East Monroe, Suite 3510, Chicago, 60603.

James Laidlaw, M.D.
Chairman, Governmental Affairs Council

★

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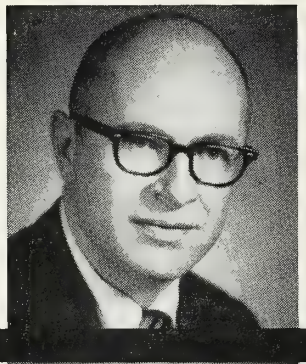
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Opinion & Dialogue

Should a specially prepared package insert be made available to patients?



Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration

The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the



Dr. James H. Sammons
Executive Vice President
of the American
Medical Association

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

Illinois Society—American Association of Medical Assistants

Kankakee County Chapter

SECOND ANNUAL SYMPOSIUM

So They May Live

Saturday, November 8 & Sunday, November 9, 1975
Holiday Inn, Bradley, Illinois

Saturday, November 8, 1975

6:30 P.M.	Registration
7:25 P.M.	Welcome — Helen LaMore, Kankakee County President
7:30 P.M.	Evening Program
	Tom McVey, EMT — Kankakee City Fire Department
	Robert Marvin, M.D. — Role of the physician in the Emergency Room
	Joanne Carter, R.N. — Coronary Care Nurse, Riverside Hospital, Kankakee
	CPR Recipient — "Patients Point of View"
	Hospitality Room — 3rd Floor — Tower

Sunday, November 9, 1975

8:00 A.M.	Registration & Coffee
9:00 A.M.	Morning Program
	Welcome — Helen LaMore, Kankakee County President
	Welcome — Mrs. Norma Sawyer, Kankakee County Medical Auxiliary President
	Introduction of Instructors
	CPR Lecture & Demonstration — Mrs. Phyllis Kirchner, R.N., M.S., Nursing Instructor, Kankakee Community College & State Faculty CPR Instructor Trainer, Kankakee County Heart Association
11:30 A.M.	Cash Bar
11:45 A.M.	Luncheon
	Welcome — P. W. Sawyer, M.D., Kankakee County Medical Society President
	Door Prizes
1-3 P.M.	Practice Session with assistance of instructor in small groups
3-4 P.M.	Return demonstrations to instructor and issuance of course completion cards

For further information, contact General Chairman, Miss Bonnie Anderson,
431 N. Grand Ave., P.O.B. 25, Bradley, IL. 60915, 815/932-5508

REGISTRATION FORM

Registration Fee: $9.00 (includes luncheon)

Deadline for registration: October 30, 1975

Make Check Payable to: Kankakee County Chapter, Illinois Society, AAMA

Mail to: Ms. Judy Knorr, Registration Chairman
1309 East Court Street, Kankakee, Illinois 60901

Name: _____

Address: _____

Member? _____ If yes, chapter name _____
Yes/No

Employers Name and Address: _____

Illinois Foundation for Medical Care

IFMC may use up to $40,000 from the $25 ISMS special assessment fund to establish an ambulatory patient review data system. It was announced that the Crescent County Foundation, comprising Kane, Lake, DuPage, and McHenry Counties, has been established and affiliated with IFMC.

Blue Cross-Blue Shield

Dr. Morton Adler informed the Board that while Blue Shield agrees with the principle of a uniform claim form, it cannot adapt the AMA approved standard form to its computer equipment. In response to questions from the Board, Dr. Adler said Blue Shield will not insist on physicians using the Blue Shield form and that, if a doctor submits an AMA form, the additional information Blue Shield needs will be obtained individually and processed manually.

Mental Health

Pointing out that the constitutional ramifications of the new alcoholism control act are monumental, Dr. LeRoy Levitt, Director of the Illinois Department of Mental Health, asked ISMS to help the department work out the implementation problems so that the program can be operational by July, 1976. The Board was informed that Council on Mental Health's Committee on Alcoholism and Drug Dependence is prepared to monitor preparations for implementation of the act and determine problems brought about by its implementation.

Dr. Leavitt also indicated that the constitutionality of Illinois law prohibiting the use of hospital permit physicians is now before the Supreme Court and awaiting decision.

CNA Upgrades Allowable Charges

John Olsen, CNA representative, informed the Board that his company has computed all usual and customary charges for 1974 and will upgrade some of its allowable Medicare fees up to 17.9 percent in fiscal 1976.

Bureau of Health Insurance

Ed Stec, of the Bureau of Health Insurance, informed the Board that he is planning to meet September 19 with the medical society executives of six Great Lakes states to discuss Medicare, institutional planning and utilization review. He urged medical staffs to become involved in hospital budgeting and long-range planning under Section 234 of PL 92-603. He also advised that physician members of utilization review committees cannot be reimbursed for reviewing the same cases for HASP and a hospital UR committee.

Medical Assistants

Magda Brown, president of the Illinois Chapter, IMAA, reported that the medical assistants' national convention will be held in Chicago in 1976 and urged cooperation of physician employers.

Comprehensive Health Planning

Dr. Mark Lepper, Director of Comprehensive Health Planning for Illinois, informed the Board that no matter how physicians feel about PL 936-641, the federal Health Planning Act, they should work with the agencies implementing this act so that physician input will be assured.

Constitution & Bylaws

The Committee on Constitution & Bylaws was instructed to prepare amendments to the ISMS bylaws that would:

1. Describe the procedures for nominating ISMS members for appointment to

AMA Councils and committees.
2. Define the responsibilities of the Illinois delegation and Illinois representatives on AMA councils and committees to the ISMS House of Delegates.
3. Require the Illinois delegation to the AMA to make meaningful reports to the House of Delegates to which it owes primary responsibility.

Govermental Affairs

The Board commended Dr. George Wilkins and the 1974-1975 Council on Governmental Affairs for their success during the recent legislative session. During the session, ISMS supported more bills than it opposed, with the ISMS position being sustained on 88 percent of the bills reaching final action.

ISMS will urge the governor to sign the following bills into law:

HB 611, permitting immediate minification of x-ray films.

HB 1369, defining death as the irreversable cessation of total brain function for purposes of the Uniform Anatomical Gift Act.

HB 1964, requiring the Department of Registration and Education to promulgate mandatory standards for continuning medical education for persons licensed under the Medical Practice Act.

HB 2086 and 1092, safeguarding confidentiality in connection with the Department of Mental Health's five-year plan.

HB 2692, 2693, establishing a medical disciplinary system.

SB 739, allowing delegation of certain tasks to physician assistants.

SB 968, extending the liability exemption provisions of the Use of Human Tissues Act.

SB 1024, the ISMS malpractice proposal.

ISMS will request the governor to veto SB 254, which is intended to allow chiropractors to be reimbursed by Blue Shield.

Legislation Concerning Death

The Medical Legal Council was instructed to draft for the Board's approval legislative proposals that would:

1. Assure that the rights of all parties (physician, patients, relatives, etc.) are guaranteed when a terminal patient requests that his physician not use extraordinary life support measures to prolong life.
2. Provide a legal definition of death in order to facilitate research in the area of transplant surgery.

Emergency and Disaster Care

At the request of the Council on Governmental Affairs, the Board instructed the Committee on Emergency and Disaster Care to:

1. Conduct a statewide study to determine the availability of emergency room care, the type of care available and the frequency with which the emergency room is used in non-emergency situations.
2. Prepare a detailed position statement, including statistical and other factual data on the problems involved in providing emergency care in rural areas.
3. Prepare legislative alternatives to HB 1496, a bill to regulate ambulances, should the bill prove to be unsupportable.

School Physicals

ISMS representatives to the CHP Task Force on School Physicals were directed to re-examine HB 3048, (to be heard by an interim study commission during the summer months), to determine whether it meets the specifications of the ISMS position on school physicals. ISMS will attempt to amend the bill so that the advisory

committee to be established will include two or three physicians, one of whom shall be a family practitioner and one a pediatrician.

Medical Examiner System

In cooperation with other groups interested in abolishing the coronor system, the Governmental Affairs Council will attempt to have re-introduced legislation that would establish a statewide medical examiner system in accordance with ISMS policy.

Mental Health Insurance

The Council on Mental Health and Addiction was directed to work with the Illinois Psychiatric Society in resolving differences of opinion on legislation that would include mental illness coverage in health insurance policies as an option or a mandatory provision. The Board requested that a position be developed and forwarded to the Executive Committee for preparation of appropriate testimony to be laid before the interim study commission dealing with this subject.

Hearing Aid Dealers/Audiologists

In view of pending legislation to license hearing aid dealers, the Board reactivated its Committee on Ear, Nose and Throat, with Drs. Jack D. Clemis, Irwin Horwitz and Burton Soboroff, all of Chicago, as members. The committee was directed to develop for the Board approval a comprehensive position on the treatment of the hard of hearing and the ethical relationship between physicians and audiologists/hearing aid dealers.

Informed Medical Consent

The Medical Legal Council was directed to work with the American College of Surgeons and other organizations concerned with the problem of informed medical consent to determine if patients are being adequately informed as to possible bad effects of treatment they are to undergo. The Council will recommend an ISMS position on pending legislation which would require a physician to inform his patient of every possible effect of a treatment, prior to the patient's agreeing to submit to the treatment.

Marijuana

The Council on Mental Health and Addiction will assemble significant scientific information about the effects of marijuana and draft a position statement for the use of the Board in implementing ISMS policy when decriminalization or legalization legislation is introduced again in the General Assembly.

Generic Drugs

The Medical Legal Council, with members of the Committee on Drugs and Therapeutics as consultants, will compile information to support the ISMS position on anti-substitution of drugs and report its findings to the Board to be used as testimony before an interim study commission of the legislature this summer.

National Health Insurance

ISMS will investigate reports that the Illinois Department of Public Health is using public funds to promote a particular form of National Health Insurance on college campuses and at county fairs.

Nutrition

The Council on Social and Medical Services and its Committee on Health Care of the Poor and Rural Problems will re-draft legislation to coordinate all nutritional services in Illinois. Budgetary restraints kept this type of legislation from passage in the last General Assembly.

Geriatric Training

The Board denied a request from the Council on Social and Medical Services to conduct a study of the present status of geriatric training in Illinois medical schools, stating that this was not an appropriate area for medical society involvement.

Prison Medicine

ISMS will coordinate a conference on prison medicine to examine the issues, problems and solutions of providing medical care in penal institutions. The conference for physicians practicing in prisons, prison reform groups, the Illinois Department of Corrections, local community groups and other interested parties was strongly supported by the Board contingent upon adequate funding being obtained.

Mental Health Department's Five-Year Plan

Representatives of the Council on Mental Health and Addiction and the Illinois Psychiatric Society will meet to discuss the Five-Year Plan of the Illinois Department of Mental Health and Developmental Disabilities, with a view to developing a written commentary for Executive Committee approval and which, subject to Executive Committee approval, would be used for presenting testimony at one of the public hearings scheduled this fall.

Child Abuse

ISMS will publicize details of SB 525, the new Child Abuse Law, which expands the number of people required to report such cases and permits physicians to take temporary custody of suspected abused children.

Interprofessional Code

The Chairman of the Medical Legal Council was authorized to meet with the chairman of the Illinois State Bar Association's medical legal relations committee to discuss possible changes in the Interprofessional Code that might equalize the respective obligations of the two professions.

National Health Manpower Act

ISMS will support amendments to the National Health Manpower Act which would remove control of medical residence training programs from HEW and would eliminate the involuntary service requirement for which a medical school graduate would be obligated as a payback provision of capitation assistance received by his school.

Relations with Members

The Executive Committee will consider the possibility of establishing an unofficial deputy trustee system in order to increase the Board's personal contacts with individual members and with county societies and branches of CMS. ◄

Statement on Medicaid Budget Cuts

Illinois Association of Health Care Facilities
Illinois Hospital Association
Illinois Nursing Home Association
Illinois Pharmaceutical Association
Illinois State Medical Society
Chicago Hospital Council
Chicago Retail Druggists Association
County & Non-Profit Nursing Home Association

When Governor Walker announced his $50 million cut in the Medicaid budget, he stated that the cut would be achieved by "improving management controls and tightening up procedures." . . . and he assured Medicaid recipients they would continue "to receive the medical care to which they are entitled."

He then proceeded to reduce the management appropriation by only $800,000 and slashed $49.7 million in Medicaid service funds. This was a health care cutback . . . not a welfare cutback, with the victims being medically indigent patients. How can the state maintain the current level of medical services on a budget that has been reduced by $50 million?

The reduction in payment levels was a unilateral decision by Governor Walker. It was never discussed with Medicaid providers. Most of us were not aware of this decision until the public announcement was made . . . and we still have not received the details! In fact, neither has the Legislative Advisory Committee to the Department of Public Aid.

The organizations listed above represent 12,000 physicians . . . 3,500 pharmacists . . . 278 hospitals . . . and 450 nursing homes. We have tolerated increasing amounts of paperwork . . . we have tolerated low payments and unbelievable payment delays . . . but we will not tolerate this discriminatory action against Medicaid patients!

Governor Walker may think his action was politically expedient. We charge that it was irresponsible. It is totally unfair for the Governor to jeopardize the quality and availability of care for Medicaid patients.

It also appears that Governor Walker has chosen to ignore federal regulations governing Medicaid reimbursement. These directives specifically state that fee structures must be designed to enlist the participation of enough providers to insure that the availability of care for Medicaid patients equals the availability for the general population.

Governor Walker's action discourages provider participation. We anticipate that a large number of providers will be forced to reduce Medicaid services . . . or even withdraw from the program. Those in the inner city—where Medicaid recipients comprise the bulk of their patients—may be forced to abandon the area, leaving those patients without any services at all.

In a letter which was sent to the Governor, we have demanded a meeting to formulate an alternative to his arbitrary cuts in the Medicaid budget. We are willing to meet with Govenor Walker as early as tomorrow in an effort to avoid a health care crisis in this state.

If the Governor refuses to modify or rescind his budgetary decision, the organizations represented here will consider every possible recourse, including legal action against the State of Illinois.

▲ **Milwaukee Psychiatric Hospital** { Intensive, dynamic psychotherapy for adults and adolescents, individually planned activity therapy.

▲ **Milwaukee Sanitarium** { Geriatric program of superior care . . . custodial services for persons with chronic emotional illness.

▲ **Dewey Center** { Acute detoxification and inpatient treatment for alcoholic dependency, daily schedules, broad supportive services.

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The First Day of Internship

The "Housestaff News" is designed for interns and residents. News items and short articles of interest to housestaff will be considered for publication; materials should be sent to Michael Hughey, M.D., 711 Laurel Avenue, Wilmette, Ill. 60091.

The first day of internship arrives and passes, usually without very much fanfare, and new interns are deeply involved in patient care and learning responsibilities. Days pass, and their clinical judgement and skills grow, sometimes imperceptibly, sometimes in leaps and bounds. Sleepless nights and the worries of having to perform many tasks for the first time, and performing them correctly, occupy their thoughts.

By the time several months have passed, most interns have learned not to panic at the first sight of blood, and if they don't know all there is to know about a clinical problem, they soon will. They have mastered many of the basic skills, and they have become more comfortable in their role as housestaff physicians. This is the time when advice to housestaff will be listened to intently, when the panic of the first few days or weeks has passed and there is time for each intern to comfortably reflect on his goals and the goals of his program director.

It is probably easiest for residents to give advice to interns. Being closest to the problems and demands of internship, and having daily contact with those demands, the residents can give their advice freely, unencumbered by the past experience of years of internships. It is probably far more difficult for departmental chairmen, with their greater perspective, to give advice to interns, yet this advice is far more valuable, because it is given from the perspective that only time and years of experience can bring.

It was with this in mind that each of the departmental chairmen at Evanston Hospital was asked for his advice on ways new interns could gain the most knowledge and experience and how to avoid common pitfalls. The response to this question was gratifying and the replies of inestimable value to the new interns. Some of the replies are shown below. Others will be shown at a later date.

Thomas McElin, M.D., Chairman of the Department of Obstetrics and Gynecology, emphasized the importance of the development of attitudes. He believed these four concepts to be the most useful:

> "You must acknowledge that as of this day your life and your lifestyle are forever changed. Until you die you are constantly a Doctor of Medicine and you are never 'off call.' You may be on vacation and there is an accident at the beach and your are immediately 'on duty.' You may be dining in a restuarant and a medical emergency may arise and you are 'on duty.' On the beginning day of a residency, you are assuming responsibilities entrusted to no other segment of the citizenry and you must always be cognizant of this fact and you must never be unfaithful to this obligation which you have coveted and have achieved."
>
> "Loyalty to the attending staff of the hospital in which you practice as a resident and loyalty to your medical conferees in the hospital in which you will ultimately practice as a staff physician and loyalty to the hospital itself is almost inevitably repaid in kind. The conscientious house officer is unquestionably rewarded with greater responsibility, greater time and greater teaching effort by his seniors and greater respect by his peers."
>
> "'Be kind to nurses!' The nursing staff of the hospital represents the physician's major ally within the hospital. The physician-nurse relationship is a critical one and must be maintained at as high a professional level as is conceivably possible. The very same concept applies to the administration of the hospital. The 'triad' of physician-nurse-administration is what makes a hospital 'run' and it is this triad which makes a 'great hospital.'"
>
> "Use your every available, free moment to read and to study. The practice of medicine is a continuing learning experience and while there must be appropriate time for rest and relaxation, in every day you must be certain that you increase your total knowledge of the most fascinating subject in the world, the 'care and feeding' and the provision of the most superior medical management to fellow humans in distress."

Edward Scanlon, M.D., Chairman of the Department of Surgery, placed emphasis on avoiding two common problems during residency and while in practice:

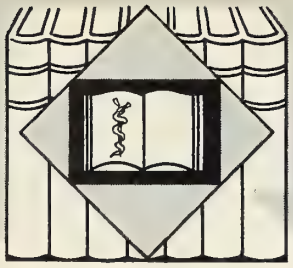
> "I think the one place where housestaff tends to become most discouraged is the repetitive performance of some small detailed procedure. What the housestaff physician has to learn is that these detailed maneuvers need to be done many times so that they become a habit and so that he can concentrate on judgement matters. The driver who has to think about how to shift gears or steer the car cannot concentrate on really important things and is a dangerous driver on the highway."
>
> "One further point I would like to make is that major problems rarely arise as the result of a single incident. Rather, they are the summation of a great many small incidents. In retrospect, when one analyzes an untoward major incident, it tends to be explained away by if, and if, and if. It is in an effort to break this chain of incidents that we insist on such meticulous attention to detail. Otherwise, the one in a million occurrence will happen all too often."

David Ingall, M.D., Chairman of the Department of Pediatrics, stressed the goals of residency in his comments. Communication, in particular, is paramount to Dr. Ingall:

> "The goals of a resident are to develop qualities of leadership as a physician, teacher, and consultant; to demonstrate the capacity for critical thinking and independent investigation; and to learn to use brief periods of time for study interspersed in the rigorous schedule of clinical medicine. For the young physician, the period of transition from academic life to the practice of medicine provided by residency demands proficiency in basic skills, curiosity, and a critical

(Continued on page 269)

the doctor's library



COLOR ANATOMY AND KINESIOLOGY OF THE HAND. Hosein A. Motamed, M.D., Published and distributed by the author. 7141 North Kedzie Avenue, No. 1504, Chicago, Illinois 60645. 1973. 160 pages, 127 illustrations. $50.

This rather unique book contains 120 color plates displaying the anatomy of the forearm and hand in dissected fresh human hands. Its first 40 pages relate to the bones of the forearm and hand and there are 23 pages on the forearm and hand muscles. There are many color photographs of the neurovascular system and several pages on fascia of the hand.

The book is only 145 pages and represents a record of the author's personal preparation, study, and photography of 120 fresh and 60 cadaver hands. This unusual and very good reference atlas of human anatomy sells for $50.00.

T. R. Van Dellen, M.D.
Editor

EMERGENCY MEDICAL SERVICES: BEHAVIORAL AND PLANNING PERSPECTIVES, Noble, J., Wechsler, H., LaMontagne, M., and Noble, M., eds. Behavioral Publications, New York, 1973.

This new book represents a compilation of articles taken from the recent (1958-1973) medical literature which deal with the organization and planning of a community's complete emergency medical care.

The components of such a system are described in one paper by William Gemma, et al. as: 1. detection and communication; 2. transportation; 3. treatment—at the site, in transit, and in the treatment facility.

The authors have organized these papers into four sections. Each section is preceded by a valuable introduction which outlines the subject and summarizes its content. The first section entitled, "The Emergency Health Care System," contains four studies which present different definitions of such a system, with the author's conclusions as to how to deal with the rapidly increasing use of the hospital's emergency facilities.

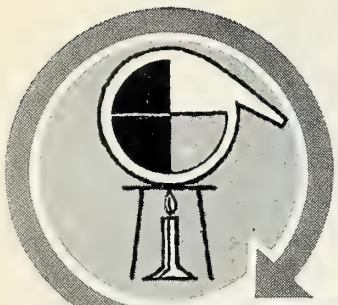
This is followed by a section containing six papers which deal with the changing patterns in the role of the hospital emergency room. Geographic location, socioeconomic patterns and physician-patient relationships have been studied and related to emergency room use. The final two sections deal with transportation, communication, standards and policies.

This book will be most valuable to those physicians, administrators, and legislators who are responsible for the organization, planning and implementation of a community's resources into an overall plan for providing adequate emergency medical services. In addition, physicians and administrators at the individual hospital level may also benefit from those chapters which deal with changing patterns of emergency room utilization and standards of care. The concise introduction to each section will help direct these readers to the appropriate papers.

Stuart M. Poticha, M.D.

Musical Hallucinations

Auditory hallucinations have been associated with a wide variety of organic and functional disorders. Complex musical hallucinations are less common but have been described as a symptom of both cortical and subcortical neurologic disease. We report the case of a 64-year-old woman, profoundly deaf since her early teens, who developed almost constant musical hallucinations. Before her deafness, the cause of which had never been found, she had demonstrated musical talent. Her hallucinations took the form of music that she had learned or heard prior to her deafness, such as religious hymns, popular tunes, and portions from semi-classical compositions. (Francis M. Forster and Stephen A. Barron: "Musical Hallucinosis in a Deaf Person." *Wisconsin Med. Jl.* (Feb.) 1974, pg. S21).



new pharmaceutical specialties

By Paul Dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Drugs—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

COMBINATION DRUGS

COMBIPRES — Hypotensive Rx

Manufacturer:	Boehringer-Ingelheim, Ltd.
Composition:	Clonidine HCl 0.1 and 0.2 mg. Chlorthalidone 15 mg.
Indications:	Hypertension
Contraindications:	Severe renal or hepatic diseases.
Dosage:	Adjust to response of patient.
Supplied:	Tablets

LO/OVRAL — Progesterone-Estrogen Comb. Rx

Manufacturer:	Wyeth Laboratories
Composition:	Norgestrel 0.3 mg. Ethinyl Estradiol 0.03 mg.
Indications:	Contraception
Warnings and Precautions:	See package insert.
Dosage:	1 tablet daily for 21 consecutive days, then discontinue for 7 days.
Supplied:	Tablets

MAALOX Plus — Antacid o.t.c.

Manufacturer:	William H. Rorer, Inc.
Composition:	Balanced combination of magnesium and aluminum hydroxides. Simethicon
Indications:	Relief of hyperacidity
Dosage:	2 to 4 tablets, q.i.d. 2 to 4 tsp. suspension q.i.d.
Supplied:	Tablets and suspension.

NALDEGESIC — Nasal Decongestant o.t.c.

Manufacturer:	Bristol Laboratories
Composition:	Acetaminophen 325 mg. d-pseudoephedrine HCl 15 mg.
Indications:	Temporary relief of symptoms of the common cold.
Dosage:	Adults, 2 tablets t.i.d. Children, 6-12 yrs., 1 tablet t.i.d.
Supplied:	Tablets

SINEMET — Muscle Relaxants—Parkinsonism Rx

Manufacturer:	Merck Sharp & Dohme
Composition:	Carbidopa 10 and 25 mg. (New Single Drug) Levodopa 100 and 250 mg.
Indications:	Idiopathic Parkinson's disease.
Contraindications:	Patients receiving monoamine oxidase inhibitors.
Warnings and Precautions:	See package insert.
Dosage:	Adjust to patient's requirements. Maintenance dose, 3-6 tablets 25/250 per day.
Supplied:	Tablets, 10/100 mg. 25/250 mg.

DUPLICATE SINGLE DRUGS

BISCOLAX — Laxative o.t.c.

Manufacturer:	Fleet Co., Inc.
Nonproprietary Name:	Bisacodyl
Indications:	For relief of constipation.
Dosage:	Adults: 2 to 3 tablets, 1 suppository. Children: 1 to 2 tablets, 1 suppository.
Supplied:	Tablets, 5 mg. Suppositories, 10 mg.

BRETHINE — Bronchodilator Rx

Manufacturer:	Geigy Pharmaceuticals
Nonproprietary Name:	Terbutaline Sulfate
Indications:	Bronchial asthma and reversible bronchospasm.
Contraindications:	Hypersensitivity to sympathomimetic amines.
Dosage:	1 tablet t.i.d.
Supplied:	Tablets, 5 mg.

ESTROPAN — Hormones Estrogens Rx

Manufacturer:	Panray Div., Ormont Drug & Chemical Co., Inc.
Nonproprietary Name:	Conjugated Estrogens
Indications:	Menopause and post-menopausal symptoms.
Precautions:	See package insert.
Dosage:	Follow package insert.
Supplied:	Tablets, 0.625 and 1.25 mg.

LEMPAY Ty-Med Caps — Coronary Vasodilator Rx

Manufacturer:	Lemmon Pharmacal Company
Nonproprietary Name:	Papaverin HCl
Indications:	Relief of cerebral & peripheral ischemia associated with arterial spasm.
Dosage:	1 capsule q. 12 h.
Supplied:	Capsules, prolonged release.

PROMACHEL — Tranquilizer Rx

Manufacturer:	Rachelle Laboratories
Nonproprietary Name:	Chlorpromazine HCl
Indications:	Management of manifestations of psychotic disorders.
Contraindications:	See package insert.
Dosage:	See package insert.
Supplied:	25, 50, 100 and 200 mg.

NEW DOSAGE FORMS

BACTRIM Suspension — Urinary antibacterial Rx

Manufacturer:	Roche Laboratories
Composition:	5 cc. contains: Trimethoprim 40 mg. Sulfamethoxazole 200 mg.
Indications:	Chronic urinary tract infections.
Dosage:	Adults, 4 teaspoonfuls every 12 hrs. for 10-14 days.
Supplied:	Bottles, 16 oz.

BRICANYL Tablets — Bronchodilator Rx

Manufacturer:	Astra Pharmaceutical Products, Inc.
Nonproprietary Name:	Terbutaline Sulfate
Indications:	Bronchial asthma and reversible bronchospasm.
Contraindications:	Hypersensitivity to sympathomimetic amines.
Dosage:	1 tablet t.i.d.
Supplied:	Tablets, 5 mg.

KAON-CL TABS — Potassium Replacement Rx

Manufacturer:	Warren Teed Pharmaceuticals, Inc.
Nonproprietary Name:	Potassium Chloride
Indications:	Potassium depletion and supplementation, digitalis intoxication.
Contraindications:	See package insert.
Dosage:	Adjust to patient's requirements.
Supplied:	Sugar coated tablets, 500 mg.

Housestaff News

(Continued from page 266)

approach characterized by a questioning attitude and an identification of unsolved problems."

"The development of the ability to communicate clearly and effectively with parents, physicians, and paramedical personnel is recognized as a primary aspect of graduate medical education. It is incumbent on the resident to establish and maintain open lines of communication with all physicians by providing information about their patients. The effective physician accepts the challenge to develop the ability to communicate and to increase stamina to tolerate those who cannot. Each person lives in a world of his own to some extent. To understand another's point of view is usually complex since people come and go from different backgrounds, pressures, problems, and feelings. Communication within a general hospital reflects the quintessence of these interactions at each point in time and the resident's efforts to understand other members of the staff are rewarded by the satisfaction of knowing that willingness to exchange information and ideas provides patients with comprehensive, quality care."

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ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
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Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

OCTOBER, 1975

Anesthesia

REGIONAL ANESTHESIA & THERAPEUTIC NERVE BLOCKING
For: All physicians. 5-day Course. Oct. 6-10. Chgo. **CME Credit:** 40 hrs. AMA Cat. 1. **Fee:** $300. **Reg. Limit:** 8. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

ELECTROCARDIOGRAPHY FOR ANESTHESIOLOGISTS
For: All physicians. 5-day Course. Oct. 27-31. Chgo. **CME Credit:** 35 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 35. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

CME Planning

INTRODUCTION TO CME TECHNIQUE
For: Hospital DME's; Program Chairman, Medical Faculty, CME Planners. Weekend Workshop. Oct. 24-26. Oak Brook Hyatt House. **CME Credit:** 14 hrs. AMA Cat. 1. **Fee:** $160. **Reg. Limit:** 20. **Reg. Deadline:** Oct. 10. **Sponsor, Contact:** ICCME, 55 E. Monroe, Chicago, Ill. 60603. Attention: Dr. Leonard Stein, Executive Director.

Endocrinology

PARATHYROID HORMONE, VITAMIN D AND CALCITONIN: PHYSIOLOGY AND DISEASE
For: All MDs. Lecture. **Speaker:** Louis M. Sherwood, MD, Michael Reese Hosp. Oct. 21, 8:00 PM, Highland Park, Ill. **Fee:** None. **Sponsor, Contact:** Highland Park Hospital, 718 Glenview Ave., Highland Park, Ill. Susan Stuttle, Administrative Secretary.

CLINICAL ENDOCRINOLOGY AND METABOLISM
For: All MDs. Symposium. Oct. 29, Indiana Univ. Med. Center. **CME Credit.** 6 hrs. AMA Cate. 1. **Fee:** $35. **Sponsor, Contact:** Indiana Univ. School of Med., Div. of CME, 1100 W. Michigan St., Indianapolis, 46202. John Roscoe, Assistant Director.

Internal Medicine

CLINICAL RHEUMATOLOGY—MODERN CONCEPTS IN DIAGNOSIS AND TREATMENT
For: All MDs, Nurses. Symposium. Oct. 9, Richmond, Ind. **CME Credit:** 6 hrs. AMA Cat. 1. **Fee:** $35. **Sponsor, Contact:** Indiana Univ. School of Med., Div. of CME, 1100 W. Michigan St., Indianapolis, Ind. 46202. John Roscoe, Assistant Director.

ILLINOIS SOCIETY OF INTERNAL MEDICINE ANNUAL MEETING
For: All MDs. Speech by The Hon. Philip M. Crane, Member of Congress (R., Ill.). Oct. 10, Drake Hotel, Chicago. **Reg. Deadline:** Oct. 5. **Co-Sponsors:** American College of Physicians and Illinois Society of Internal Medicine. **Contact:** ISIM, 55 E. Monroe, Suite 3510, Chicago, Ill. 60603, Wendy Smith, Administrative Secretary.

HYPERTENSION
For: All MDs. Lecture. **Speaker:** Ray W. Gifford, MD, Cleveland Clinic Foundation. Oct. 31. Chicago. **CME Credit:** 1 hr. AMA Cat. 1; AAFP. **Fee:** None. **Co-Sponsors:** Martha Washington Hosp. and Smith, Kline & French Labs. **Contact:** Martha Washington Hosp., 4055 N. Western Ave., Chicago, Ill. 60618. Fernando Lopez-Fernandez, MD, Med. Dir.

UPPER GASTROINTESTINAL ENDOSCOPY
For: Internists. 5½ day course. Oct. 10-15. Chgo. **CME Credit:** 33 hrs. AMA Cat. 1. **Fee:** $350. **Reg. Limit:** 8. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

Medicine

PHARMACOLOGY OF ANTI-HYPERTENSIVE DRUGS
For: All MDs and Nurses. Lecture. **Speaker:** T. R. Sherrod, MD, PhD. Univ. of Ill. Med. School. Oct. 25. Chicago. **CME Credit:** 1 hr. AMA Cat. 1; **Sponsor, Contact:** Martha Washington Hosp., 4055 N. Western Ave., Chicago, Ill. 60614. Fernando Lopez-Fernandez, MD, Med. Dir.

MEDICINE FOR TODAY—Fall Sessions

For: Practicing physicians in all specialties. IAFP's 26th Annual Lecture Series, with A-V and Q&A supplement. Emphasis on Family Practice, Gynecology, Gastroenterology, Electrolytes & Cardiology. *CME Credit:* 30 hrs. (maximum, for Fall & Spring sessions) AAFP Prescribed, AMA Category 1. *Fee:* $100 AAFP mbrs., $110 non-mbrs. Meets in these cities on dates noted:

***Belleville*—Oct. 23, 30, Nov. 6, 13, 20, Dec. 4.**
***Berwyn*—Oct. 22, 29, Nov. 5, 12, 19, Dec. 3.**
***Beverly*—Oct. 22, 29, Nov. 5, 12, 19, 26.**
***Centralia*—Oct. 29, Nov. 12, 26.**
***Champaign*—Oct. 23, Nov. 6, 20.**
***Chicago Nearwest*—Oct. 22, 29, Nov. 5, 12, 19, 26.**
***Chicago North*— Oct. 22, 29, Nov. 5, 12, 19, 26.**
***Chicago Southwest*—Oct. 22, 29, Nov. 5, 12, 26, Dec. 3.**
***Harvey*—Oct. 22, 29, Nov. 5, 12, 26, Dec. 3.**
***Hinsdale*—Oct. 22, Nov. 5, 19.**
***Kankakee*—Oct. 21, 28, Nov. 11, 18, 25, Dec. 2.**
***Park Ridge*—Oct. 22, 29, Nov. 5, 12, 19, 26.**
***Peoria*—Oct. 23, Nov. 6, 20.**
***Rockford*—Oct. 23, 30, Nov. 6, 13, 20, Dec. 4.**
***Rock Island*—Oct. 30, Nov. 6, 13.**
***Springfield*—Oct. 23, Nov. 13.**

For details of time and place, contact: Ill. Academy Family Phys., 14 E. Jackson Blvd., Suite 1532, Chicago, IL 60604.

Nuclear Medicine

CLINICAL APPLICATIONS OF THE GAMMA SCINTILLATION CAMERA
For: Radiologic Techs. Symposium. Oct. 31-Nov. 1. Indiana Univ. Med. Center. **Fee:** $75. **Sponsor, Contact:** Indiana Univ. School of Med., Div. of CME, 1100 W. Michigan St., Indianapolis, Ind. 46202. John Roscoe, Assistant Director.

Pathology

ADVANCES IN HEPATOLOGY
For: MDs, Nurses, Paramedics. Seminar. **Speaker:** Dr. Gregorio Chejfec. Oct. 28, Elmhurst, Ill. **CME Credit:** 1 hr. AMA Cat. 1. **Fee:** None. **Sponsor, Contact:** Memorial Hospital of DuPage County, Avon & Schiller, Elmhurst, Ill. 60126. John Huss, MD, Dir. of Med. Education.

SPECIAL COURSE IN GYNECOLOGIC PATHOLOGY
For: Pathologists. 5-day Course. Oct. 6-10. Chgo. **CME Credit:** 35 hrs. AMA Cat. 1. **Fee:** $300. **Reg. Limit:** 25. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chgo. 60612.

Psychiatry

SLEEP DISORDERS
For: Psychiatrists. Lecture Series. **Speaker:** William C. Dement, MD, PhD., Stanford Univ. Oct. 29. Arlington Park Hotel. **CME Credit:** 6 hrs. AMA Cat. 1; AAFP. **Fee:** $25. **Sponsor, Contact:** University of Chicago, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago, Ill 60637. Mrs. Elaine Ehrman, Sec.

Radiology

CHEST RADIOLOGY
For: MDs; Nurses. Lecture. **Speaker:** Leon Love, MD, Foster McGaw Hosp. Oct. 8. Chicago. **CME Credit:** 1 hr. AMA Cat. 1; AAFP. **Fee:** None. **Sponsor, Contact:** Martha Washington Hospital, 4055 N. Western Ave., Chicago, Ill. Fernando Lopez-Fernandez, MD, Med. Dir.

CPHA offers new resource book: *Quality Assurance in Long-Term Care Facilities: Planning Improved Patient Care Through Extended Stay Review, Discharge Planning, and Medical Care Evaluation.* The book is fundamentally a "how to" manual with sufficient examples of Medical Care Evaluation Studies to permit implementation of a quality assurance program in any long-term facility.
For information, write: Commission on Professional and Hospital Activities, 1968 Green Road, Ann Arbor, Mich. 48105.

Surgery

SURGICAL CONTROL OF PAIN
For: Surgeons. Lecture. **Speaker:** John F. Mullan, MD, Brain Research Inst. Oct. 8. Chicago. **CME Credit:** 6 hrs. AMA Cat. 1. **Fee:** $30. **Reg. Limit:** 250. **Sponsor, Contact:** University of Chicago, Frontiers of Medicine, 950 East 59th Street, Box 451, Chicago, Ill 60637. Mrs. Elaine Ehrman, Secretary.

Trauma

INTENSIVE CARE OF ACUTE SPINE INJURIES
For: MDs, Nurses, Paramedics. Seminar. **Speaker:** Dr. Roland Manfredi. Oct. 7. Elmhurst, Ill. **CME Credit:** 1 hr. AMA Cat. 1. **Fee:** None. **Sponsor, Contact:** Memorial Hospital of DuPage County, Avon & Schiller, Elmhurst, Ill. 60126. John H. Huss, MD, Dir. of Med. Education.

NOVEMBER, 1975

CME Planning

IDENTIFYING CME NEEDS THROUGH MEDICAL AUDIT
For: Hospital DME's; Program Chairmen, Medical Faculty, CME Planners. Weekend Workshop. Nov. 21-23. Oak Brook Hyatt House. **CME Credit:** 14 hrs. AMA Cat. 1. **Fee:** $160. **Reg. Limit:** 20. **Reg. Deadline:** Nov. 7. **Sponsor, Contact:** ICCME, 55 E. Monroe, Chicago, Ill. 60603. Attention: Dr. Leonard Stein, Executive Director.

Laryngology

COURSE IN LARYNGOLOGY AND BRONCHOESOPHAGOLOGY
For: Physicians or Residents in Otolaryngology. 6-Day Course. Nov. 3-8. Chgo. **Fee:** $350. **Reg. Limit:** 20. **Sponsor, contact:** U. of Ill. Abraham Lincoln School of Med., 1855 W. Taylor St., Chicago, Ill. 60612. Att'n: Marion B. Wickland.

Medicine

FRONTIERS OF EMERGENCY MEDICINE
For: All MDs. Lecture. **Speaker:** Peter Rosen, MD, Professor of Emergency Medicine. Nov. 12. Chicago. **CME Credit:** 3 hrs. AMA Cat. 1. AAFP. **Fee:** $20. **Reg. Limit:** 250. **Sponsor, Contact:** University of Chicago, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago, Ill. 60637. Attention. Mrs. Elaine Ehrman.

Neurology

FOURTH ANNUAL CLINICAL NEURO-OPHTHALMOLOGY
For: Ophthalmologists, Neurologists. Symposium. Nov. 12. Indiana. **CME Credit:** 6 hrs. AMA Cat. 1. **Fee:** $35. **Sponsor, Contact:** Indiana Univ. School of Med., Div. of CME, 1100 W. Michigan St., Indianapolis, Ind. 46202. John Roscoe, Assistant Director.

Obstetrics/Gynecology

WHAT'S NEW IN OB-GYN?
For: All MDs. Symposium. Nov. 19-20. Indianapolis. **CME Credit:** 12 hrs. AMA Cat. 1. AAFP. **Fee:** $50. **Sponsor, Contact:** Indiana Univ. of Med. Div. of CME, 1100 W. Michigan St., Indianapolis, Ind. 46202. John Roscoe, Assistant Director.

Oncology

SYMPOSIUM ON LYMPHOMAS
For: All MDs. Symposium. Nov. 5. Indianapolis. **CME Credit:** 6 hrs. AMA Cat. 1. **Fee:** $35. **Co-Sponsors:** Marion County Cancer Society and Indiana Univ. School of Med. **Contact:** Indiana Univ. School of Med., Div. of CME, 1100 W. Michigan St., Indianapolis, Ind. 46202. John Roscoe, Assistant Director.

MODERN RADIOTHERAPY IN CANCER MANAGEMENT
For: MDs, Nurses, Paramedics. Seminar. **Speaker:** Dr. Wagih Shehata. Nov. 25. Elmhurst, Ill. **CME Credit:** 1 hr. AMA Cat. 1. **Sponsor, Contact:** Memorial Hospital of DuPage County, Avon & Schiller, Elmhurst, Ill. 60126. John H. Huss, MD, Director of Medical Education.

Ophthalmology

CONTACT LENS SEMINAR
For: Ophthalmologists. Symposium. Nov. 19. Indianapolis. **CME Credit:** 6 hrs. AMA Cat. 1. **Fee:** $35. **Sponsor, Contact:** Indiana Univ. School of Med., Div. of CME, 1100 W. Michigan St., Indianapolis, Ind. 46202. John Roscoe, Assistant Director.

Pediatrics

GENERAL PEDIATRICS
For: GPs. 5-Day Course. Nov. 10-14. Chgo. **CME Credit:** 35 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 70. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago, 60612.

Pediatric Cardiology

HYPERTENSION IN CHILDHOOD
For: All MDs, Nurses, Paramedics. Seminar. **Speaker:** Dr. Sachchida Sinha, Loyola Stritch School of Med. Nov. 11. Elmhurst, Ill. **CME Credit:** 1 hr. AMA Cat. 1. **Fee:** None. **Sponsor, Contact:** Memorial Hospital of DuPage County, Avon & Schiller, Elmhurst, Ill. 60126. John H. Huss, MD. Director of Medical Education.

Surgery

SPECIALTY REVIEW COURSE IN GENERAL SURGERY
For: Surgeons. 10½ Day Course. Nov. 3-14. Chgo. **CME Credit:** 94 hrs. AMA Cat. 1. **Fee:** $400. **Reg. Limit:** 350. **Sponsor, contact:** Cook County Grad. School of Med., 707 S. Wood St., Chicago, Ill. 60612.

PLASTIC SURGERY FOR GENERAL SURGEONS
For: General Surgeons. 3-Day Lecture/Workshop Course. Nov. 20-22. Ann Arbor, Mich. **CME Credit:** AMA Cat. 1. **Fee:** $150. **Sponsor, contact:** Office of Intramural Ed., Dept. of Postgrad. Med. & Health Prof. Ed., U. of M., G1109 Towsley Center, Ann Arbor, Mich. 48104.

Surgery & Radiology

MID-AMERICAN BREAST CANCER SYMPOSIUM
For: Surgeons and Radiologists. Nov. 7-8. Madison, Wis. **CME Credit:** 9 hrs. AMA Cat. 2. **Fee:** $35. **Reg. Limit:** 350. **Sponsor, contact:** Wisconsin Breast Cancer Detection Foundation, Inc., 7803 Mineral Point Rd., Madison, Wis. 53717. Att'n: Oscar Louik.

Radiology

RUSH MEDICAL COLLEGE COURSE ON COMPUTED TOMOGRAPHY
For: Radiologists, Neurologists, Neurosurgeons. Nov. 6. Chicago. **CME Credit:** 11 hrs. American College of Radiology, Cat. 1. **Fee:** $175. **Reg. Limit:** 200. **Co-Sponsors:** American College of Radiology and Rush Medical College. **Contact:** Department of Diagnostic Radiology, Presbyterian-St. Lukes Hospital, Chicago, Ill. 60612. Attention: Michael S. Huckman, MD.

Urology

1975 AMERICA UROLOGICAL ASSOCIATION POSTGRADUATE SEMINAR
For: All MDs. Symposium. Nov. 14-16. Indianapolis. **CME Credit:** 24 hrs. AMA Cat. 1. **Fee:** $175. **Co.-Sponsors:** American Urological Association and Indiana Univ. School of Med. **Contact:** Indiana Univ. School of Med., Div. of CME, 1100 W. Michigan St., Indianapolis, Ind. 46202. John Roscoe, Assistant Director.

DECEMBER, 1975

Endocrinology

AMENORREA: CAUSES AND TREATMENT
For: All MDs. Lecture. **Speaker:** Robert L. Rosenfeld, MD, Assoc. Prof. of Pediatrics, Univ. of Chicago. Dec. 2. Highland Park, Ill. **Fee:** None. **Sponsor, Contact:** Highland Park Hospital, 718 Glenview Ave., Highland Park, Ill. 60035. Attention: Mrs. Susan Stuttle.

Family Medicine

CARDIOLOGY FOR FAMILY PHYSICIANS
For: Family Physicians. One-Day Lecture Course. Dec. 3. Ann Arbor, Mich. **CME Credit:** AMA Cat. 1; AAFP Prescribed. **Fee:** $50. **Co-Sponsors:** Michigan Academy for Family Practice and Univ. of Mich. Dept. of Postgraduate Med. & Health Professions Ed. **Contact:** Univ. of Mich., G1109 Towsley, Ann Arbor, Mich. Attention: Mary F. O'Brien, Program Associate.

ACUTE CARDIAC CARE
For: All MDs. 3-Day Course. Dec. 3-5. Chicago. **CME Credit:** 21 hrs. AMA Cat. 1. **Fee:** $125. **Reg. Limit:** 80. **Sponsor, Contact:** Cook County Grad. School of Med., 707 S. Wood St., Chicago, Ill. 60612.

BASIC OBSTETRICS
For: All MDs. 5-Day Course. Dec. 1-5. Chicago. **CME Credit:** 35 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 50. **Sponsor, Contact:** Cook County Grad. School of Med., 707 S. Wood St., Chicago, Ill. 60612.

General Medicine

INTENSIVE CORONARY CARE
For: Physicians, Nurses, Paramedics. Seminar. **Speaker:** Dr. J. P. Stokes, Mayo Clinic. Dec. 2. Elmhurst, Ill. **CME Credit:** 1 hr. AMA Cat. 1. **Fee:** None. **Sponsor, Contact:** Memorial Hospital of DuPage County, Avon & Schiller, Elmhurst, Ill. 60126. John H. Huss, MD, Director of Medical Education.

GASTROINTESTINAL EMERGENCIES—SURGICAL AND MEDICAL
For: All MDs. Symposium. Dec. 4. Richmond, Indiana. **CME Credit:** 6 hrs. AMA Cat. 1. **Fee:** $35. **Sponsor, Contact:** Indiana Univ. School of Med., Div. of CME, 1100 W. Michigan St., Indianapolis, Ind. 46202. John Roscoe, Assistant Director.

Internal Medicine

ADVANCES IN THE DIAGNOSIS AND MANAGEMENT OF HYPERTENSION
For: All MDs. Lecture. **Speaker:** Suzanne Oparil, MD, Assoc. Prof. Dept. of Med. Dec. 10. Chicago. **CME Credit:** 3 hrs. AMA Cat. 1; AAFP Elective. **Fee:** $20. **Sponsor, Contact:** Univ. of Chicago, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago, Ill. 60637. Attention: Mrs. Elaine Ehrman.

Medical Audit

PAS TUTORIAL
For: MDs, Hospital Administrators, Health Record Analysts, Chiefs of Medical Records. 2-Day Course. **Speaker:** Vergil N. Slee, MD, Pres. CPNA. Dec. 10-11. Ann Arbor, Mich. **CME Credit:** 12 hrs. AMA Cat. 1; AAFP Elective; AOA Cat. 2-0; ACGOPMS-Class 2. **Fee:** $135 per 3 registrants from a hospital. **Reg. Deadline:** 10 days prior. **Sponsor, Contact:** Commission on Professional and Hospital Activities, 1968 Green Rd., Ann Arbor, Mich.

PAS INSTITUTE
For: MDs, Hospital Administrators, Health Record Analysts, Chiefs of Medical Records. 1-Day Institute. **Speaker:** Vergil N. Slee, MD, Pres. CPNA. Ann Arbor, Mich. **CME Credit:** 6 hrs. AMA Cat. 1; AAFP Elective; AOA Cat. 2-0; ACGOPMS-Class 2. **Fee:** $65. **Sponsor, Contact:** Commission on Professional and Hospital Activities, 1968 Green Rd., Ann Arbor, Mich.

Orthopaedics

OFFICE ORTHOPAEDICS
For: FPs; GPs; Orthopedists. Symposium. Dec. 17. Indianapolis. **CME Credit:** 6 hrs. AMA Cat. 1. **Fee:** $35. **Sponsor, Contact:** Indiana Univ. School of Med., Div. of CME, 1100 W. Michigan St., Indianapolis, Ind. 46202. John Roscoe, Assistant Director.

Pediatrics

CURRENT PEDIATRIC MANAGEMENT
For: Ped, FP, GPs. Symposium. Dec. 3. Indianapolis. **CME Credit:** 6 hrs. AMA Cat. 1. **Fee:** $35. **Sponsor, Contact:** Indiana Univ. School of Med., Div. of CME, 1100 W. Michigan St., Indianapolis, Ind. 46202. John Roscoe, Assistant Director.

Psychiatry

THE PRIVATE SECTOR OF MENTAL HEALTH SERVICES PRESENT AND FUTURE
For: Psychiatrists. Lecture. **Speaker:** Jacob Fishman, MD, Pres. of American Health Services, Inc. Dec. 17. Chicago. **Fee:** None. **Sponsor, Contact:** Institute of Psychiatry, Northwestern Med. School, 320 E. Huron St., Chicago, Ill. 60611. Attention: Dr Barbara A. Kay.

Surgery

HAND SURGERY—THE STATE OF THE ART
For: Orthopedic Surg.; Surgical Residents; Industrial Surg. Three-Day Course. Dr. Robert R. Schenck, Course Chairman. Dec. 4-6. Chicago. **CME Credit:** 16 hrs. AMA Cat. 2; AAFP Elective. **Fee:** $200. $100 (Residents). **Co-Sponsors:** Rush-Presbyterian St. Luke's Medical Center and American Society for Surgery of the Hand. **Contact:** Robert R. Schenck, MD, 1725 W. Harrison St., Suite 33, Chicago, Ill. 60612.

SPECIALTY REVIEW COURSE IN GENERAL SURGERY, PART II
For: Surgeons. 11-Day Course. Dec. 1-12. Chicago. **CME Credit:** 99 hrs. AMA Cat. 1. **Fee:** $400. **Reg. Limit:** 150. **Sponsor, Contact:** Cook County Grad. School of Med., 707 S. Wood St., Chicago, Ill. 60612.

Urology

SPECIALTY REVIEW COURSE IN UROLOGIC PATHOLOGY & X-RAY
For: Urologists. 2½ Day Course. Dec. 4-6. Chicago. **CME Credit:** 20 hrs. AMA Cat. 1. **Fee:** $100. **Reg. Limit:** 75. **Sponsor, Contact:** Cook County Grad. School of Med., 707 S. Wood St., Chicago, Ill. 60612.

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

ALBANY: Small town on bank of Mississippi river needs general practitioner. Ideal modern brick building with parking area available. Two recently new, well equipped hospitals at Clinton—8 miles away. Nice community, two factories nearby. Contact: Mrs. Warden Welch, Park Street, Box 441, Albany 61230 (309-887-4461) (10)

AURORA—Board eligible or certified gynecologist to join established corporation in town of 75,000—30 miles west of Chicago. Guaranteed salary 1st year with partnership arrangements thereafter. Option to buy in anytime. G. J. Shimkus, M.D., 143 So. Lincoln Ave., Aurora, 60505. 312-896-7892. (1)

BELLEVILLE: Pulmonary Disease Specialist—Part Time Director wanted for modern 329 bed full service community hospital with extensive building program. Complete specialty backup. 500,000 served by local hospitals. No pulmonary specialist in hospital or private practice. Contact: Matthew Eisele, M.D., Memorial Hosital, 4501 North Park Drive, Belleville, 62223. (618) 233-7750, Ext. 345 (11)

BELLEVILLE: Emergency Medical Services Director wanted for modern 329 bed full service community hospital. Areawide Trauma Center. Emergency Department expanding to 10,900 square feet. Full time physician coverage since January, 1971. Complete specialty backup. Financial arrangements negotiable. Contact: Matthew Eisele, M.D., Memorial Hospital, 4501 North Park Drive, Belleville, 62223. (618) 233-7750, Ext. 345. (11)

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CHADWICK: Town needs DOCTOR—have been without Doctor since former retired. Complete office building—available for immediate use. Location in center of rich farming community—good recreational facilities nearby. A very good place to live. Contact: Frank W. Mest, POB 148, Chadwick 61014 (815-684-5173) (10)

CHICAGO: Medical Center N.W. Side of Chicago with clinical laboratory, X-rays, physical therapy. 2 Family Physicians, members A.A.P.F., looking for a young, well trained, ambitious F.P. Privileges in hospital with Department of Family Practice, F. S. Steinitz, M.D., 3653 W. Lawrence, Chgo. 60625 (312-478-6000). (12)

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CHICAGO: Physician interested in full time in family practice. Complete office facilities. Potential is unlimited. Contact: C. Rai, M.D., 415 W. Belmont, Chicago, 60657, (313) 348-6567. (1)

LITCHFIELD: GP's & Peds. Located on I 55 midway between Springfield & St. Louis. Office space available in new medical arts building. Guaranteed income and other financial assistance available. New 140 bed hospital with full time ER coverage by trauma center physicians. Practice opportunities unlimited. Contact: Lee Johnson, M.D., St. Francis Hospital (217-324-2191) or John Short, 723 N. Van Buren, Litchfield 62056 (217-324-3937). (10)

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ROCKFORD: Orthopedic Surgeon, General Internist, Cert/Elig. to associate with a 25 man multi-specialty clinic in a city of 150,000 population serving an area of 300,000 people; minimum salary guarantee with no upper limits; retirement plan and fringe benefits; teaching available through local Medical School—a branch of Univ. Ill. Contact: N. R. Dougherty, M.D., Canfield Clinic, LTD., 1215 N. Alpine Rd., Rockford 61107, (815-397-0180) (10)

ROUND LAKE: Family Practioner need in a growth community. Complete office facility available, due to recent death of GP. Family and Industrial practice—drawing population 25,000. Location North Eastern area, centered between Chicago and Milwaukee. Three hospital affiliation—fully accredited—total 954 beds. Excellent opportunity. All recreational facilities nearby. Contact: Doris Brundza, POB 488, Round Lake 60073, 312-546-4623 (11)

SAVANNA: Population 5,000. Service area 20,000. Modern 38 bed acute care facility; developing family practice group. Have openings for three family practitioners or internists. Will provide office space and financial assistance. Located in beautiful recreational area on Mississippi River. Excellent school system. Contact: M. J. Stretton, Savanna City Hospital, Savanna 61074 (815-273-7751) (10)

VANDALIA: Population 6,000. Family physicians needed. Office space available. Hospital with 100 beds, all services. An excellent school system and all denominations of churches. One hour from St. Louis on the interstate highway. Local lake for boating and fishing, close to the Carlyle Lake. Recreational facilities. Contact: D. H. Rames, M.D., 1029 N. 8th St., Vandalia, 62471 (618-283-3012) or Larry Harrison, Administrator, Fayette County Hospital, Vandalia, 62471 (618-283-1231). 12)

WAUKEGAN: North Chicago. Population 100,000 - 40 miles north of Chicago. Primary care physician needed to head existing medical and dental clinic with a growing patient load. Clinic to work in cooperation with medical school and local hospital to train primary care physicians. Salary open. Contact Mrs. Lopez — Waukegan-North Chicago Partnership for Health Clinic, 701 Tenth Street, North Chicago, 60064, 312-473-2744. (10)

WEST DUNDEE: Small town—45 miles NW from Chicago by Tollroad—Active, well established Family Practice—Large drawing area—Only 1 other physician in town—2 large modern hospitals nearby—Office, equipment and residence available (Rental, sale or financing) —Martin C. Koenig, M.D., 118 N. 3rd, West Dundee 60118. Call (312) 428-6725 or 426-2600 (12)

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PSYCHIATRIST: Board eligible or board certified with license to practice in Illinois or ability to obtain license. Primary affiliation with multi-specialty medical clinic/hospital and contractual arrangement with community mental health center. This is an excellent opportunity in northwestern Illinois ninety miles west of metropolitan Chicago. Employment will involve psychiatric services to a network of community based programs as well as private practice. Job profile flexible to suit individual. Income and fringe benefits highly competitive. Contact Albert E. Graff, Executive Director, Sinnissippi Mental Health Center, Dixon-Sterling Freeway, Dixon, Illinois. Phone collect (815) 284-6611, or Contact John Tatum, Administrator, Medical Arts Clinic, 403 E. First Street, Dixon, Illinois 61021. Phone collect (815) 288-5531.

DOCTOR WANTED to work in modern three doctor medical center presently staffed with one doctor. Laboratory and x-ray equipment available. New ambulance which is manned by 50 trained EMTA volunteers. Hospital nearby. Located in beautiful Calhoun County Illinois between the Mississippi and Illinois rivers within one hour drive of St. Louis. Excellent hunting and fishing facilities. Contact Calhoun County Farm Bureau, Hardin, Illinois 62047. Phone 618-576-2233.

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CARDIOLOGISTS wanted on a part-time basis for the interpretation and serial comparison of ECGs. Experience with interpretation of Holter recordings is also desirable. Please apply in writing to: Dr. Louis C. Lax, c/o TELEMED Corporation, 2345 Pembroke Ave., Hoffman Estates, Illinois, 60172; or phone (312) 884-0900.

PSYCHIATISTS WANTED to join staff of private, non-profit, community treatment facility. Lakefront location. Inpatient, out-patient, day treatment available. Broad range of treatment modalities. State licensed, JCAH approved. Affiliated with medical school for psychiatric residency training. Contact London Memorial Hospital, 4700 N. Clarendon, Chicago, Illinois (312) 728-7100.

INTERNIST AND PEDIATRICIAN—Immediate opening—5-man multispecialty group needs third internist and second pediatrician. Group includes Gen. Surgeon and OB-Gynecologist, all Board Certified. Located next door to Community Hospital with recently completed additional primary care facilities. Community close to Metro-Milwaukee and two hours from Metro-Chicago. First year salary open. Excellent fringes including approved profit-sharing plan. Contact J. L. Algiers, M.D. (Int.) or P. M. Donahue, M.D., (Ped.) or Clinic Manager at Parkview Medical Associates, Ltd., 1004 East Sumner St., Hartford, WI 53027 or collect 414-673-5745.

GENERAL PRACTITIONER, RADIOLOGIST, INTERNIST OR GENERAL SURGEON. VA Hospital with active teaching and residency program. Salary based on qualifications according to VA salary scale. 40-hour basic work week. Liberal fringe benefits. Non-discrimination in employment. Write or call Chief of Staff, VA Center, Jackson, MS 39216, 601-362-4471.

ANESTHESIOLOGIST—Board certified or eligible—needed as associate in well established Indiana group servicing active progressive Surgery and OB in large community hospital. Excellent professional and financial opportunity including available malpractice insurance. Reply in confidence, providing CV to Box 857 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, Ill. 60603.

PSYCHIATRIST: Board Certified or eligible. Multidisciplinary Community Mental Health Department of nationally known Health Center —urban Chicago. Comprehensive child and adult mental health services, individual psychotherapy, active sustaining care program, available attending status with back-up teaching Hospital. Excellent fringe benefits, Salary commensurate with experience. Write or call Dr. Mollie E. Oroff, Chief of Psychiatric Services, Mile Square Health Center, Inc., 2045 West Washington Blvd., Chicago, Illinois 60612.

INTERNIST PREFERRED. Part-time Position: Regional medical officer Bureau of Disability Insurance Social Security Administration three or four 3 hour sessions per week—$76.00 per session serves as chief medical consultant to the regional representative in working with top medical advisors in a six state region. Submit curriculum vitate to: Bureau of Disabilty Insurance, 300 South Wacker Drive, 12th floor, Chicago, Illinois 60606. Attention: Analysis and evaluation section.

FOR SALE, LEASE OR RENT

FOR RENT 4010 W. MADISON ST., CHICAGO—OFFICE SPACE available for Medical Doctors. Physician short area; large number of people in need of additional physicians. 1-2-3 Room Suites. Immediate Possession. Call: Illinois Property Management Corp., Mr. R. M. Ryan, Agent. 312-VA 6-4438 or 379-1133.

LIBERTYVILLE, ILLINOIS. New office space available Building completion scheduled for October, 1975. Lease, ownership, or partnership available. Call collect (312) 362-4740 or (312) 834-0638.

DOCTORS WHY PAY RENT: Buy an 800 sq. ft. Medical suite luxuriously finished and absolutely independent in a newly completed Medical Center in Barrington, Ill., a desirable place to start a practice and to live. Ample paved parking. Just a few blocks from the future Good Shephard Hospital. Excellent terms. Write Box 852, Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chgo., Ill. 60603.

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MEDICAL SUITE FOR RENT in new medical building directly across the street from Kewanee, Ill.'s only hospital, (115 bed). Great need for eye, ear, nose, throat man, general practice man or OB & Gynecologist. 18,000 city, 1 hr from Peoria, or Quad Cities, 2½ hr from Chicago. Phone Ed Babka (319) 588-2073 regarding suite, or Miss Elizabeth Baethke, (309) 853-3361 regarding medical needs of Kewanee, Ill.

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BLUE SHIELD REPORT FOR *Illinois Physicians*

Blue Shield Benefit Improvements for Chrysler Corporation Employees

Effective October 1, 1975, the following Blue Shield benefit improvements have been made for employees of Chrysler Corporation:

CHEMOTHERAPY:

Physician services will be covered for the administration of Chemotherapy drugs by infusion, perfusion or intracavitary therapy. Benefits will be provided on a hospital in-patient basis, in the out-patient department of a hospital or in a physician's office. Oral Chemotherapy or subcutaneous or intramuscular injection of drugs are excluded.

DURABLE MEDICAL EQUIPMENT:

Benefits will be provided on a Usual and Customary basis for the purchase or rental of durable medical equipment, when prescribed by a licensed physician; when reasonable and necessary for the treatment of an illness or injury; or to improve the functioning of a body member. When equipment is purchased, benefits are payable for repairs necessary to restore the equipment to a serviceable condition.

EMERGENCY CARE:

Benefits for the treatment for conditions resulting from accidental injury or for the initial examination or treatment of a medical emergency will be provided on a Usual and Customary basis.

HUMAN ORGAN AND TISSUE TRANSPLANT EVALUATION:

Benefits for physician services will include evaluation tests, to establish donor compatability and suitability for potential donors.

OUT-PATIENT PSYCHIATRIC CARE:

- A combined Blue Cross-Blue Shield maximum per member per calendar year has been increased to $800.00.

- Maximum benefit payment for psychiatric testing per member per calendar year will be increased to $75.00.

- The age differential and maximum visit restriction for family counseling will be removed.

- The member's co-payment for individual psycho-therapeutic sessions of twenty minutes or more, group therapy and family counseling will be 10% for the sixth through the tenth visit and 25% for all visits after the tenth visit.

PAP SMEARS:

Annual pap smears and more frequent pap smears for a specified medical condition will be a benefit when prescribed by a physician. This benefit covers the laboratory and pathological examinations. Physicians' services in connection with taking the smear are not covered.

PROSTHETIC APPLIANCES:

Benefits will be provided on a Usual and Customary basis for external prostheses and orthotic appliances when prescribed by a licensed physician. Benefits are provided when the external prostheses and appliances replace all or part of a body organ or replace all or part of the functioning of a permanently inoperative or malfunctioning body organ.

ROUTINE LAB SERVICE FOR OB CARE:

Payment will be provided on a Usual and Customary basis for routine laboratory service in connection with normal maternity care.

SUBSTANCE ABUSE TREATMENT PROGRAM:

Benefits will be provided for the physician's services for active employees, their spouses and eligible children for the treatment of drug abuse and alcoholism in approved residential substance abuse facilities.

The facility must be approved by Blue Cross to qualify under the program.

Medicare's Prevailing Fee Formula Implemented for Allowable Charges

Starting with the update of physicians' reasonable charge screens effective July 22, 1975, Illinois Medical Service, Part B Medicare carrier for Cook County began payment of allowable charges for Part B Medicare claims based on recent federal guidelines for applying the economic index limitation to the prevailing screens.

Physician profiles were updated in accordance with directives issued by the Social Security Administration, and the new formula for payment of allowable charges applies to fiscal year 1976 (July 1, 1975-June 30, 1976). The limitation on increases in prevailing fee levels is incorporated in Section 224-A of Public Law 92-603 (the Social Security Amendments of 1972).

Prevailing fees under the new regulations are limited to the lesser of:

(1) the prevailing fee for an individual procedure using calendar year 1974 charge data from both assigned and non-assigned claims, based on the 75th percentile of charges; or

(2) the prevailing fee for an individual procedure using calendar year 1971 charge data from assigned and non-assigned claims, **plus** a maximum increase of 17.9%.

The 17.9% limitation stipulated by the Department of Health, Education and Welfare was calculated from economic index data based on a ratio of changes in expenses of practice and changes in general earning levels. Application of the formula lowered a few calculated prevailing fees for fiscal year 1976 from those of the previous year.

Under the regulations that revised the update of reasonable charge screens, Medicare's allowable charge will be based on the lower of the submitted charge; the physician's customary charge; or the prevailing charge as limited by the economic index factor; or the rate allowed by Blue Shield in its regular business for comparable services.

REQUEST FOR A REVIEW

When a physician or patient is dissatisfied with his Medicare payment he may request a review of the claim. The request must be made in writing and be signed by either the physician or beneficiary if the claim was assigned or by the patient if assignment was not accepted. The review is a completely new, independent and critical examination of the entire claim.

A request for review must be received by the Medicare carrier (Blue Shield in Cook County) within 6 months of the date of payment. If a longer time has elapsed, the reason for late filing must be stated. The carrier may at its discretion or upon the request of the individual affected extend the period for requesting the review when good cause clearly exists.

The request for review should contain the following information:

(1) Name of the patient
(2) Health Insurance Claim Number
(3) Dates of Services
(4) Complete description of the services rendered, including any additional information not entered on the original claim. In cases of surgery, a copy of the operative report is helpful.
(5) Name of the physician who furnished the services. It is also helpful for the carrier if the date of payment and control number of the claim are indicated on the request. The date of payment appears in the upper right corner of the physician's remittance notice and the control number is shown directly under the health insurance claim number.

A form entitled "SSA-1964 Request for Review of Part B Medicare Claim" is available and may be obtained from any Social Security Administration office. The form contains all the necessary information for requesting a review. However, if the form is unavailable, a letter requesting a review is sufficient.

Claims are reviewed by a special department of the Part B carrier comprised of qualified persons who had no prior involvement with the claim nor any part of its original adjudication. If additional information is necessary to reach a decision the physician will be contacted by letter. Notification of the review determination is then sent to the parties concerned in the review. Following notification by letter and adjustments of the carrier's records, an explanation of Medicare payment is sent with an additional payment if one is authorized in the review decision. A physician may ask for information about a payment without requesting a review.

SSA Changes in Lab Certifications

The following laboratories reported changes in ownership through incorporation. The provider number assigned is unaffected:

Diagnostic Medical Laboratory
3359 West Chicago Avenue
Chicago, Illinois 60651
Provider Number: 14-8281

Winnetka Clinical Laboratory
725 Elm Street
Winnetka, Illinois 60093
Provider Number: 14-8014

The following laboratory has been approved for Procedure 110 (Bacteriology) in addition to its other approved specialties and subspecialties:

Reymar Clinical Laboratory
6032 South Halsted Street
Chicago, Illinois 60621
Effective Date: July 25, 1975
Provider Number: 14-8269

IMJ
Illinois Medical Journal

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IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or Narcan® (naloxone HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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Obituaries

***Buley, Hans,** Champaign, died July 7 at the age of 71. He graduated in 1929.

***Korman, Belle,** Chicago, died July 30 at the age of 84. A graduate of Rush Medical School in 1925, Dr. Korman was instrumental in starting the Venereal Disease Clinic here.

****Dallenbach, John,** Champaign, died Aug. 12, at the age of 93. He graduated from University of Pa. in 1906. Dr. Dallenbach had practiced medicine for over 50 years.

***Lopez-Fernandez, Fernando,** 68, Medical Director of Martha Washington Hospital and former Cuban Minister of Health, died Sept. 2. He was a member of the ISMS Committee on Accreditation. Dr. Lopez graduated from the University of Havana School of Medicine in 1934. In 1944 he was named an Under-Secretary of Public Health in Cuba. He came to Martha Washington Hospital in 1971 as Medical Director and Chairman of the Department on Continuing Education, where his CME program became a model for other hospitals.

Named an Outstanding New Citizen by the Department of Justice in 1973, Dr. Lopez came to the United States in 1966. Dr. Lopez was a clinical assistant professor of medicine at Loyola University School of Medicine and a member of numerous professional societies.

***Parker, Morris,** Chicago, died July 29 at the age of 79. He graduated from Northwestern in 1923. Dr. Parker was known as a philanthropist whose scholarships enabled many impoverished students to enter medical school.

***Reiner, Herbert,** California, passed away in August. Dr. Reiner graduated from Wien, Austria in 1930.

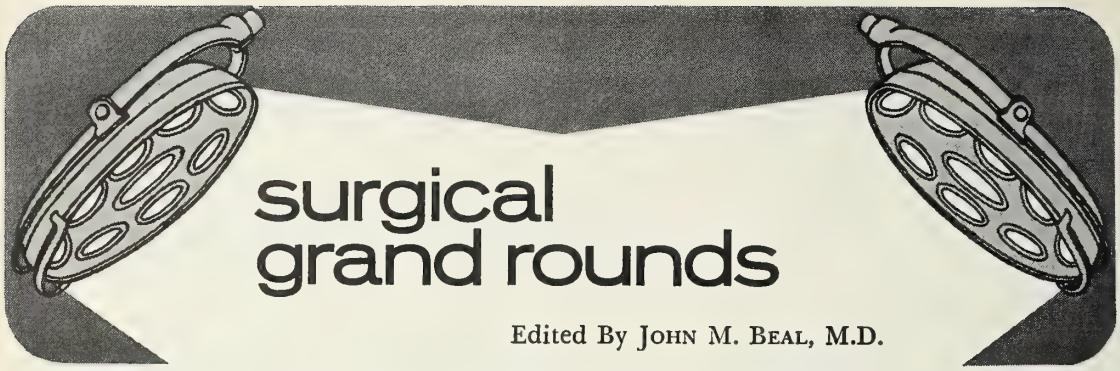
***Roberts, Dewey,** Alton, died Aug. 6 at the age of 77. He graduated from University of Illinois in 1925.

****Rosene, Gordon,** Chicago, died July 30 at the age of 82. He graduated from Rush Medical College in 1922. Dr. Rosene had practiced medicine for over 50 years.

***Rudnick, Dorrin,** Rolling Meadows, died Aug. 21, at the age of 76. Dr. Rudnick graduated from University of Illinois in 1923.

***Schwartz, Walter,** Chicago, died Aug. 31 at the age of 62. He graduated from University of Illinois in 1938.

**Indicates ISMS member*
***Indicates ISMS member and member of the Fifty Year Club*



Edited By John M. Beal, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of August 26, 1974.

Peptic Ulceration after Esophageal Resection

Dr. Emanuel Calenoff: A 59-year-old man was admitted to the Emergency Room of the Northwestern Memorial Hospital July 27, 1974 with rectal bleeding, which began that day. When examined, he was found to have normal vital signs and physical examination was unremarkable. However, hematocrit was 27% and stools were guaiac positive.

When he was admitted to the hospital, his hematocrit had fallen to 23%. Whole blood transfusions were begun. He did not complain of abdominal pain, nausea or vomiting and did not give a history of aspirin ingestion. After one week of observation and 12 units of whole blood, his hematocrit returned to normal levels and his stools became guaiac negative.

Review of his past medical history included esophagogastrectomy for squamous cell carcinoma of the distal esophagus 22 years earlier. Evidence of recurrence had not been detected during this interval. However, during the past five years he had been admitted to the hospital on four occasions with upper gastrointestinal bleeding. Hemorrhage had been manifested by both acute bleeding and chronic blood loss. During the admissions in 1969, 1970, and 1971, evaluations included multiple X-ray studies without detection of the source of bleeding. In addition, he was known to be a heavy smoker.

Approximately two weeks after admission, roentgenogram of the stomach and duodenum were obtained.

Dr. Harold Matthies: Films of the stomach and duodenum from April, 1970, and as recent as 1973, were reviewed. The stomach was in the chest, but the distal stomach appeared normal and the duodenal bulb was without a crater or source of bleeding.

The current examination (Fig. 1) demonstrated a normal duodenal bulb without evidence of ulceration. The radiologic study does not disclose the source of the patient's hemorrhage.

Dr. Emanuel Calenoff: Gastroscopy was performed and revealed essentially normal mucosa. However, there was difficulty entering the duodenal bulb through the pylorus. To determine if complete vagotomy had been accomplished 22 years earlier, a 12-hour overnight gastric aspiration was performed. A 12-hour volume of 300 ml with 10 mEg of HCl was obtained.

It was then determined that a pyloroplasty had not been performed earlier at the time of the esophageal resection. Therefore, it was postulated that pyloric outlet obstruction was present and accordingly pyloroplasty was performed. The postoperative course was uncomplicated and he was discharged one week after operation.

Dr. Robert Davis: Although endoscopic examination of the stomach failed to reveal a mucosal lesion at this time, a prepyloric ulcer had been detected by gastroscopy on a previous occasion by his internist. This finding, in association with the history of four episodes of upper gastrointestinal hemorrhage, led to the conclu-

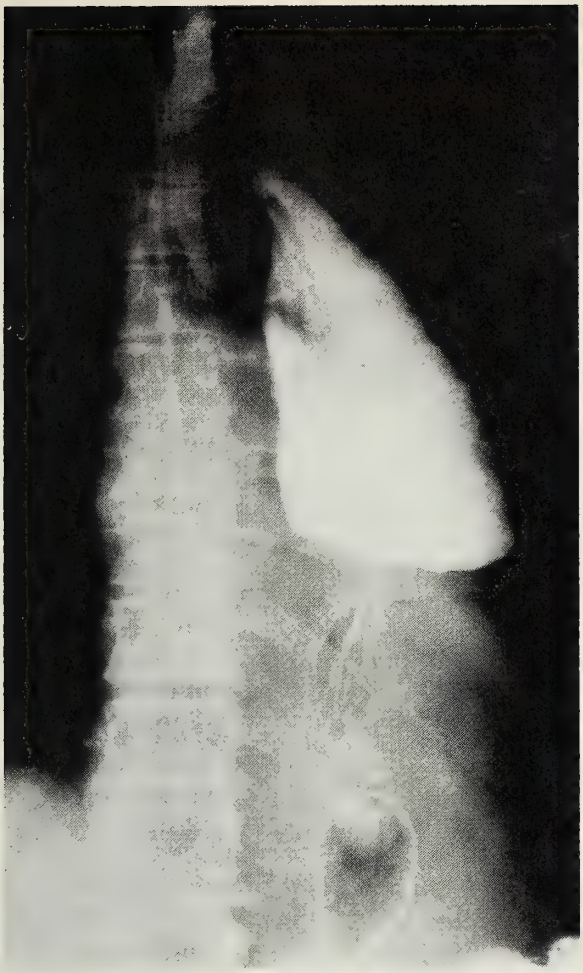


Figure 1. Upper gastrointestinal series demonstrated stomach high in chest but without evidence of ulceration.

sion that the patient was bleeding from an undetected gastric ulcer at the time of the present admission. At the time of operation, the pylorus admitted only the tip of the fifth digit of the surgeon's hand and, accordingly, a double pyloroplasty (Hines's technique) was performed.

This case supports the theory of Dragstedt who proposed that gastric ulcers result from gastric stasis with consequent excessive release of gastrin during the digestive phase of acid secretion. He had observed that after several years a number of patients with duodenal ulcer whose ulcers had healed after transthoracic vagotomy alone returned with new gastric ulceration. Dragstedt and his associates then performed a number of experiments which demonstrated increased gastric secretion from Heidenhain's pouches when vagus nerve section was performed, or when the antrum was transplanted as a diverticulum into the side of the colon.

Evidence which supports this concept has been provided by Smith and Adams from the University of Chicago who reviewed a number of cases of esophagogastrectomy, performed without pyloroplasy or other drainage procedure. Resection of the lower end of the esophagus includes a complete vagotomy, of course. In a number of these patients, proven gastric ulcers were found. The ulcers healed and symptoms improved when a drainage procedure was performed. These observations gave support to the operation performed on the patient presented today.

Dr. James Hines: Recently a study from the University of Chicago presented a 30-year follow up on the first 40 patients treated by truncal vagotomy by Dr. Dragstedt in the spring of 1943. Fifty percent of these patients had to have a second operation due to persistent gastric symptoms of stasis, nausea, vomiting, and gastric ulcerations. This does not mean that the remainder were symptom-free, but that half of the patients had symptoms so severe they had to have an outlet procedure. Those with pyloroplasty or gastroduodenostomy did better than the patients with gastroenterostomy. In many patients the second procedure was performed several years following the vagotomy. This time lag is of interest as the patients now being subjected to parietal cell vagotomy without drainage must be carefully watched for stasis. If the nerves of Latarjet to the pylorus are damaged, stasis may result and thus increase the risk of recurrent ulceration.

Dr. John Beal: This discussion of gastric ulcer is a pertinent subject and much controversy surrounds the theories of pathogenesis of gastric ulcer. Recent studies have emphasized the changes in the gastric mucosal barrier and the reflux of bile and pancreatic juice into the stomach. Credit must be given to Dragstedt for the classic studies which implicated the role of the antrum in certain patients with gastric ulcer.

One of the earliest studies of the relation between vagus nerve section and gastric ulcer was that of van Yzeren in 1901. Using rabbits, he demonstrated the development of gastric ulcers in 50 percent of the animals that were subjected to subdiaphragmatic vagotomy. He also recorded that splitting the pyloric muscle of gastroenterostomy usually prevented the development of ulcer after vagotomy. Later Kelling (1918) and Madlener (1925) demonstrated in patients that resection of the pylorus or performance of a gastrojejunostomy resulted in healing of gastric ulcers.

In 1938, Phemister and Adams reported the

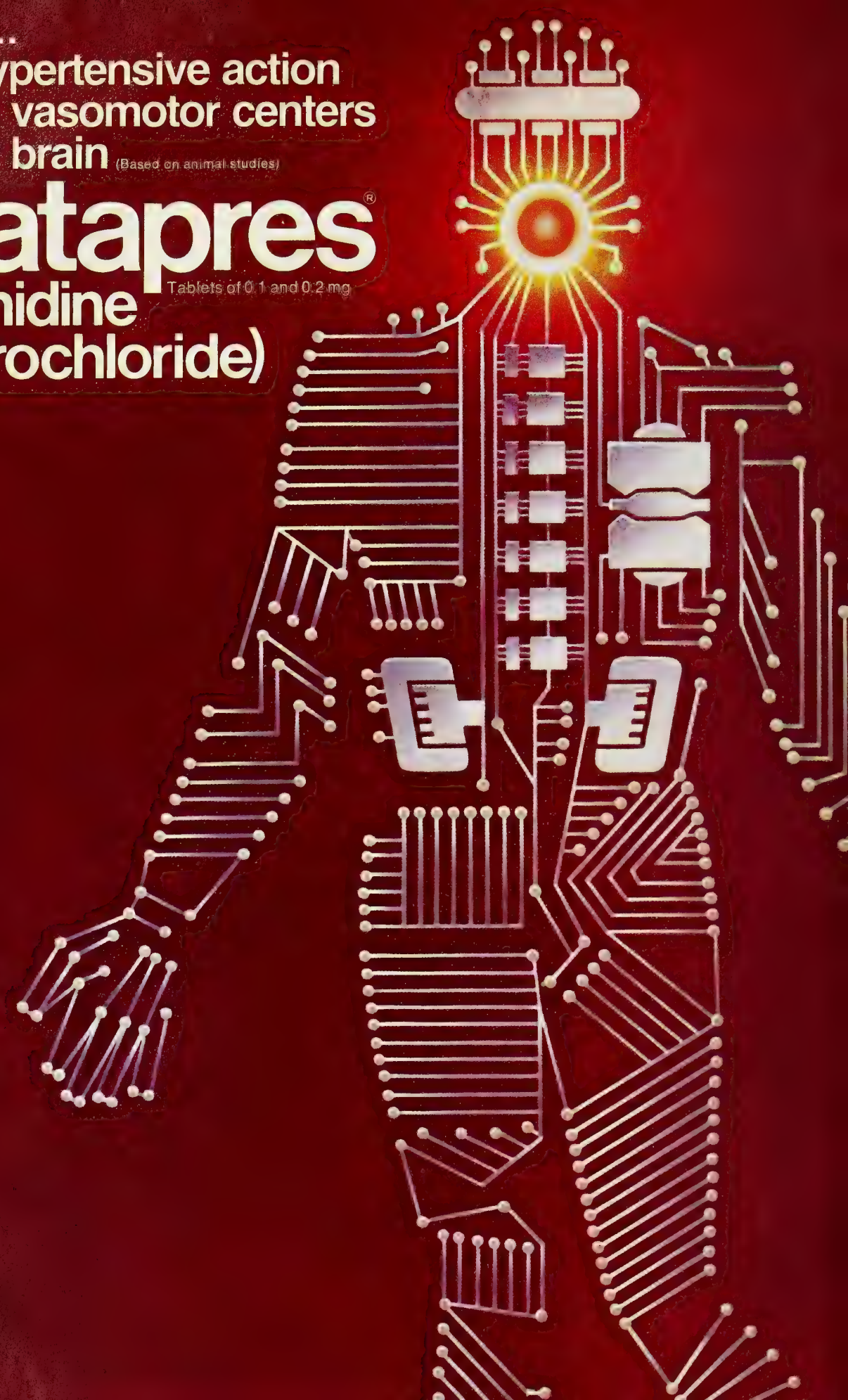
(Continued on page 294)

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The most common side effects are dry mouth, drowsiness and sedation. These generally tend to diminish with continued therapy. Other potential adverse reactions are listed in the Brief Summary.

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Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.
Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres, in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established). These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlorthalidone and papaverine hydrochloride.

Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres (clonidine hydrochloride) overdosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.

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On the Cover

In commemoration of the U.S. Bicentennial, we have used an artist's rendering of a Revolutionary War battle scene, capturing the idea that only very rudimentary medical service was available to those injured during this epic time.

Over the years, medicine has taken tremendous strides for the improvement of the quality of life. There is much Americans have to remember and much for which to be grateful.

Often it gives pleasure to remember and reminisce. This, when shared, gives pleasure and education to others. As part of the Bicentennial, the *Illinois Medical Journal* plans to serialize articles on medical history.

An open invitation is extended to Illinois physicians to submit brief articles about medicine in Illinois over the past 200 years. These could be biographical, narrative, or geographical. The Publications Committee will review these for acceptance based on authenticity, relevance to the Bicentennial, length, breadth of interest and applicability. Please send your article to IMJ, 55 E. Monroe St., Suite 3510, Chicago 60603.

Surgical Grand Rounds

(Continued from page 291)

first successful esophagogastrectomy for carcinoma of the distal esophagus. In 1950, in a discussion of papers presented at the American Surgical Association, Dr. Phemister reported the case of a 44-year-old man who had an esophagogastrectomy for carcinoma of the esophagus and two and one-half years later developed a gastric ulcer. This patient was treated by gastrojejunostomy and his gastric ulcer healed. These observations were among those that stimulated Dragstedt to pursue his studies on the relation of antral function to gastric ulcer. ◄

References

1. Dragstedt, L. R.: "The Pathogenesis of Gastric Ulcer." *Ann. Surg.* 160:497, 1964.
2. Smith, C. A., Moulder, P V. and Adams, W. E.: "Gastric Ulcer Following Esophagogastric Anastomosis for Carconima of the Esophagus or Gastric Cardia." *Ann. Surg.* 146:630, 1957.

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Warnings: *Drug Dependence*—Propoxyphene can produce drug dependence characterized by psychic dependence and, less frequently, physical dependence and tolerance. Propoxyphene will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to that of codeine although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

Usage in Ambulatory Patients—Propoxyphene may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, such as driving a car or operating machinery. The patient should be cautioned accordingly.

Usage in Pregnancy—Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, propoxyphene should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Usage in Children—Propoxyphene is not recommended for use in children, because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric age group.

Precautions: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The central-nervous-system depressant effect of propoxyphene may be additive with that of other C.N.S. depressants.

Adverse Reactions: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, lightheadedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances.

The chronic ingestion of propoxyphene in doses exceeding 800 mg. per day has caused toxic psychoses and convulsions. [011375]

DARVON® COMPOUND-65
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Contraindication: Hypersensitivity to propoxyphene, aspirin, phenacetin, or caffeine.

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Usage in Ambulatory Patients—Propoxyphene may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, such as driving a car or operating machinery. The patient should be cautioned accordingly.

Usage in Pregnancy—Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, propoxyphene should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Usage in Children—Propoxyphene is not recommended for use in children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric age group.

Salicylates should be used with extreme caution in the presence of peptic ulcer or coagulation abnormalities.

Precautions: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

The central-nervous-system depressant effect of propoxyphene may be additive with that of other C.N.S. depressants.

Phenacetin has been reported to damage the kidneys when taken in large amounts for a long time.

Salicylates may enhance the effect of anticoagulants and inhibit the uricosuric effect of uricosuric agents.

Adverse Reactions: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, lightheadedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances.

The chronic ingestion of propoxyphene in doses exceeding 800 mg. per day has caused toxic psychoses and convulsions. [011375]

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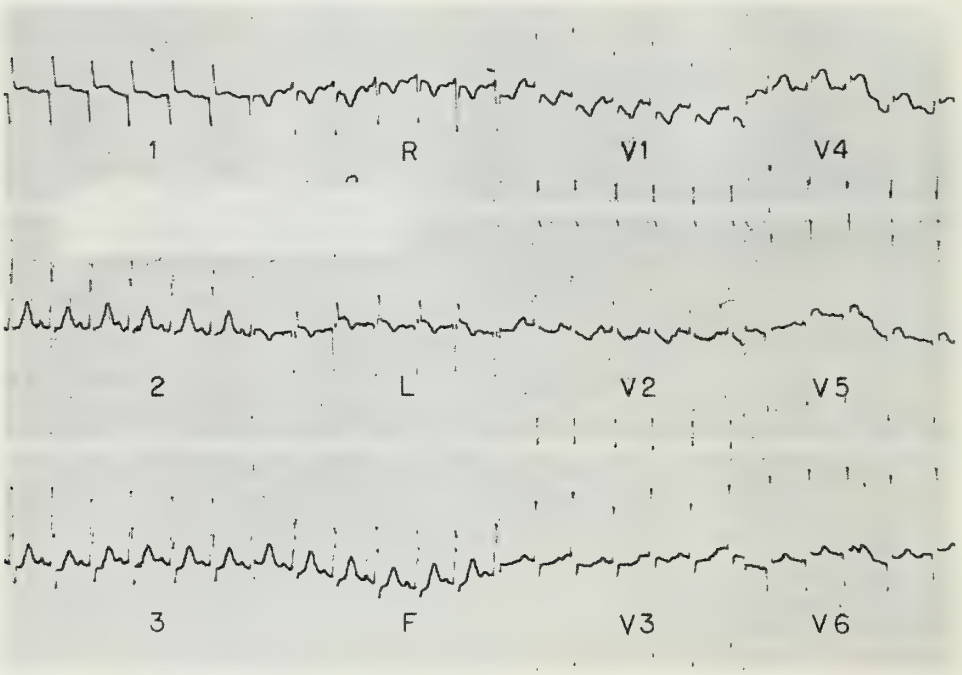
for mild to moderate pain

See summary of prescribing information on adjoining page.

ekg of the month

John R. Tobin, Jr., M.S., M.D., Rimgaudas Nemickas, M.D., Patrick J. Scanlon, M.D., John F. Moran, M.S., M.D., Sarah Johnson, M.D., and Rolf M. Gunnar, M.S., M.D./
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

A three month old baby was brought in to his pediatrician because of recurring episodes of distress usually brought on by feeding. The baby would become pale, restless, perspire, and cry with some shortness of breath. He was the product of a normal labor and delivery but had many upper respiratory infections. His physical examination was significant for a marked cardiac enlargement and a prominent third heart sound. The electrocardiogram is presented.



Questions:

1. The electrocardiogram shows:

A. Acute anterolateral wall myocardial infarction.
B. Left ventricular hypertrophy.
C. Acute pericarditis.
D. Atrial flutter with 2:1 AV block.
E. All of the above.

2. Which of the following statments are true?

A. This patient ought to have some prominent heart murmurs.
B. Congestive heart failure may be part of this clinical picture.
C. The diagnosis can be made with cardiac catheterization and angiography.
D. The treatment of this condition is surgical.
E. All of the above.

(Continued on page 301)

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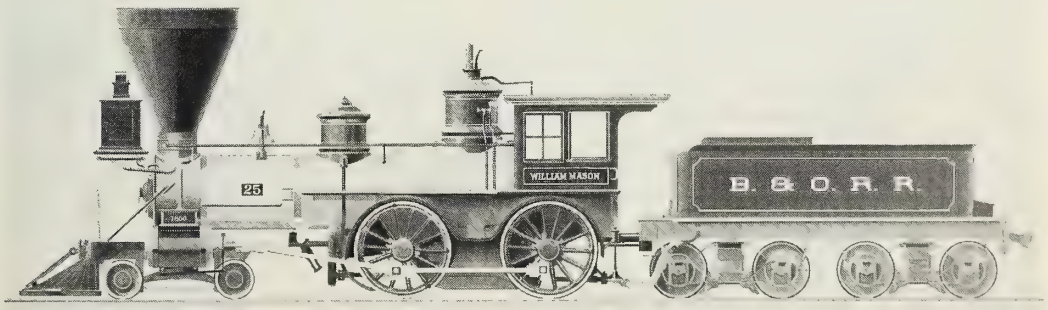
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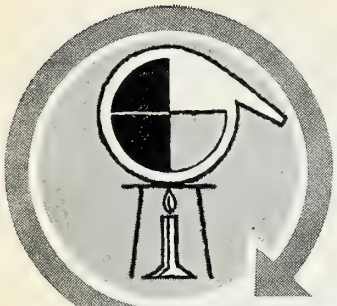
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For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines. In keeping with this tradition, the company recently commissioned a well-known illustrator to render full-color drawings of several classic locomotives... accurate to the minutest detail. The first of the series is now available. To order your print suitable for framing, write "Robitussin Clear-Tract Engine #1" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.



The William Mason (1856)



new pharmaceutical specialties

By Paul Dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Drugs—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

NEW SINGLE DRUGS

NEBCIN — Broad Spectrum Antibiotic Rx

Manufacturer:	Eli Lilly & Company
Nonproprietary Name:	Tobramycin Sulfate
Indications:	Variety of serious infections caused by susceptible strains.
Contraindications:	Hypersensitivity to Tobramycin.
Warnings:	See package insert.
Dosage:	Depending on weight of patient, refer to package insert.
Supplied:	Rubber stoppered ampules, 2 ml./80 mg. Pediatric 2 ml./20 mg. Disposable syringes, 60 mg. & 80 mg.

DUPLICATE SINGLE DRUGS

ECONOCHLOR Sol. — Ophthalmic Antibiotic Rx

Manufacturer:	Alcon Laboratories, Inc.
Nonproprietary Name:	Chloramphenicol
Indications:	Superficial ocular infections involving the conjunctiva and/or cornea caused by susceptible organisms.
Warnings:	Prolonged use should be avoided.
Dosage:	2 drops in the affected eye 3 or 4 times daily. Ointment: Apply small amount to the lower conjunctival sac 3 or 4 times daily.
Supplied:	Drop-Tainer; 15 ml., ml. 5 mg. Ointment—tubes; 3.5 Gm., 1.0%

MEPRIAM — Tranquilizer Rx

Manufacturer:	Lemmon Pharmacal Co.
Nonproprietary Name:	Meprobamate
Indications:	Anxiety and tension.
Dosage:	Adults: 1,200-1,600 mg/day in divided doses. Children; 6-12 yrs.; 100-200 mg. b.i.d. or t.i.d.
Supplied:	Tablets, 400 mg.

MOBIDIN — Non-Narcotic Analgesic Antiinflammatory Rx

Manufacturer:	B. F. Ascher & Co., Inc.
Nonproprietary Name:	Magnesium Salicylate
Indications:	Management of mild to moderate advanced rheumatoid arthritis, osteoarthritis and related diseases
Dosage:	One tablet 3 or 4 times daily, may be increased to double the dose. In rheumatic fever as many as 16 tablets may be required during 24 hours.
Supplied:	Tablets, 600 mg.

COMBINATION PRODUCTS

ARISTOCORT A — Local Corticoids Rx

Ointment

Manufacturer:	Lederle Laboratories
Composition:	Triamcinolone Acetonide 0.1% Propylene Glycol
Indications:	Inflammatory manifestations of corticosteroid-responsive dermatoses.
Contraindications:	Those usual with corticosteroids.
Administration:	Apply to affected areas 3 or 4 times daily.
Supplied:	Tubes, 15 Gm. & 75 Gm., 0.1% Tubes, 15 Gm., 0.5%

CONERSPAZ — Digestive Enzyme Rx

Manufacturer:	B. F. Ascher & Co., Inc.
Composition:	Amylolytic enzyme 30 mg Cellulytic enzyme 5 mg Proteolytic enzyme 10 mg Lipolytic enzyme 800 Ascher U. l-hyoscyamine sulfate 0.0625 mg
Indications:	Functional indigestion
Contraindications:	Glaucoma, prostatic hypertrophy and some forms of cardiac disease
Dosage:	1 to 2 tablets
Supplied:	Tablets

SEDADROPS — Sedative Rx

Manufacturer:	Merrell-National Laboratories
Composition:	Each ml. Phenobarbital 24 mg. Homatropine methylbromide 0.27 mg.
Indications:	Hyperirritability in various conditions in children.
Contraindications:	Glaucoma
Dosage:	Varies with age of children; follow package insert.
Supplied:	Bottles, 30 ml.

URISTAT — Urinary Antibacterial and Antispasmodic Rx

Manufacturer:	Lemmon Pharmacal Co.
Composition:	Atropine sulfate 0.03 mg. Hyoscyamine (sulfate) 0.03 mg. Methylene blue 5.5 m.g. Phenyl salicylate 20 mg. Benzoic acid 5 mg. Methenamine 50 mg.
Indications:	To relieve pain caused by smooth muscle spasm and adjunct in management of recurring urinary tract infections.
Contraindications:	See package insert.
Dosage:	2 tablets 4 times daily. Given after meals and at bedtime.
Supplied:	Tablets

NEW DOSAGE FORMS

ALUPENT Syrup — Bronchodilator Rx

Manufacturer:	Boehringer Ingelheim, Ltd.
Nonproprietary Name:	Metaproterenol Sulfate
Indications:	Bronchial asthma, reversible bronchospasm which may occur in association with bronchitis and emphysema.
Contraindications:	Cardiac arrhythmia associated with tachycardia
Dosage:	Children under 60 lbs: one teaspoonful 3 or 4 times daily, over 60 lbs; two teaspoonful 3 or 4 times daily
Supplied:	Syrup, 5 ml/10 mg, bottles 16 oz.

FLUROBATE Lotion — Corticoids Local Rx

Manufacturer:	Texas Pharmacal Co.
Nonproprietary Name:	Betamathasone Benzoate
Indications:	Inflammatory manifestations of corticosteroid-responsive dermatoses.
Contraindications:	Those usual with corticosteroids.
Administration:	Apply to affected areas 3 or 4 times daily.
Supplied:	Bottles, 15 ml., 0.025%

SEPTRA Susp. — Urinary Antibacterial Rx

Manufacturer:	Burroughs Wellcome Co.
Composition:	5 ml contains: Trimethoprim 40 mg Sulfamethoxazole 200 mg
Indications:	Chronic urinary tract infections
Dosage:	Adults, 4 teaspoonful every 12 hrs for 10-14 days.
Supplied:	Bottles, 8 ozs.

STATOBEX-D Caps. — Antiobesity Preparation Rx

Manufacturer:	Lemmon Pharmacal Co.
Nonproprietary Name:	Phendimetrazine tartrate
Indications:	Management of exogenous obesity as a short-term adjunct.
Dosage:	1 capsules b.i.d. or t.i.d., adjust to patient's requirement.
Supplied:	Capsules, 70 mg.

SYNOPHYLATE L.A. — Bronchodilator Rx

Manufacturer:	Central Pharmacal Co.
Nonproprietary Name:	Theophylline
Indications:	Chronic bronchial asthma and prevention of acute attacks.
Dosage:	Adults, 1 capsule (cenule) every 12 hrs.
Supplied:	Capsule, 260 mg.

VELOSEF for injection — Antibiotic Rx

Manufacturer:	E. R. Squibb & Sons
Nonproprietary Name:	Cephradine
Indications:	Variety of serious infections caused by susceptible strains.
Warnings:	Use with caution in patients sensitive to penicillin.
Dosage:	2 to 4 Gm. in divided doses. 4 times daily, i.m. or i.v.
Supplied:	Vials, 250, 500 and 1000 mg. Infusion bottles, 2 and 4 Gm.

XYLOCAINE HCl i.m. for cardiac arrhythmias — Antiarrhythmic Rx

Manufacturer:	Astra Pharmaceutical Products, Inc.
Indications:	Management of cardiac arrhythmias.
Warnings and Precautions:	See package insert.
Dosage:	300 mg. for 70 kg.
Supplied:	Ampules, 5 ml/100 mg.

EKG

(Continued from page 296)

Answers: 1. A,B 2. B,C,D

The electrocardiogram shows the pattern of acute anterolateral myocardial infarction and left centricular hypertrophy with sinus tachycardia of 150 beats/minute. This ECG added to the following clinical features suggests a diagnosis of anomalous left coronary artery with inadequate intercoronary anastomoses. The important clinical features are recurring episodes of distress, marked cardiomegaly without a significant murmur and congestive heart failure in early infancy. Although it may be difficult to prove the diagnosis with hemodynamic studies, aortic root angiography is essential to the diagnosis. The inadequate collateral coronary circulation from the right coronary to the left results in myocardial ischemia. The blood is flowing from the right coronary artery to the left coronary system in a retrograde fashion. The retrograde flow then empties into the pulmonary artery because of the lower pressure there. The prognosis is guarded since most of these patients are dead in the first year. The treatment is surgical.

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Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.
Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.
Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest
Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.
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Case Discussion In CME*

By Richard L. Byyny, M.D., and Leonard S. Stein, Ph.D./Chicago

Increasingly, physicians over the country are turning from didactic lectures to case-discussion for their continuing education, especially for in-hospital programs —partly because many such lectures do not seem to fit perceived learning needs and partly on the basis of empirical evidence.[1-3] *State and national meetings of specialty societies are adding small-group discussion to their programs,*[4,5] *thus admitting implicitly that lectures by eminent scholars do not necessarily change practitioner behavior.*

This paper outlines the advantages and disadvantages of case-discussion as it might be used in relatively-small groupings. It assumes that in most such cases there is not available sophisticated competence in group process, and accordingly focuses on simple techniques that can easily be used by any physicians interested in improving the quality of their own CME. It also offers suggestions for effective use of this learning method derived from successful experience in several Illinois hospital CME programs.

Premise, Goal, Objectives, Method

The *premise* of this method is that while no one physician can possibly know everything, within any *group* of practitioners there is an enormous fund of competence. Accordingly, the *goal* is to provide a means for practitioners in a CME program to *share* understandings and facts by helping them become involved in productive problem-solving group discussion. *Specific objectives* are: (a) Use small-group ("Team") interaction for learning by listening, questioning, and challenging the concepts of others in the Team; (b) extend Team discussion to the full Group and thus expand the knowledge/experience base; and (c) through this sharing correct misconceptions or misunderstandings, add *new* knowledge and understandings, and provide practice in clinical problem-solving.

The *method* usually most effective is to assign to each of several Teams of four the task of formulating a *single* conclusion about the problem presented. Each Team then presents its respective solution to the larger Group (five to ten teams), after which individual members of the full Group can offer additional comments and arguments and raise relevant questions—concluding with a summary statement by the moderator.

Advantages of Case-Discussion

Naturalness: it is as close to actual medical practice as is possible in a formal learning situation. At its best, it approximates the normal "corridor consultation" of health professionals, taking full advantage of the physician's professional competence.

Problem-Solving: successful case-discussion requires discussable cases, those with some problem (s) the solution to which is not immediately obvious—*e.g.*, when diagonsis is not easily made or concerning which there is no agreement on preferred treatment modalities. Thus, case discussion can increase the physician's sensitivity to the possibility of greater disability than may appear on first presentation of a patient's symptoms, by sharpening his clinical problem-solving skill.

Sharing Competence: group discussion encourages colleagues to share insights and judgments, facts and ideas. In turn, this sharing experience during CME sessions is likely to carry over to other relations in the daily practice of medicine, helping to build habits of mutual consultation on difficult problems.

This point has special relevance with respect to nurses and allied health personnel in a hospital CME program. Many hospitals invite nurses (or dieticians, laboratory technicians, respiratory therapists, *et. al.*, depending on the subject) to didactic lectures; typically they sit mute, rarely even asking questions afterwards. By contrast, nurses and allied health workers usually participate fully in small-group discussion, and thus contribute their understanding of patient problems to physician learning—while gaining both increased understanding of the medical problem involved and fuller appreciation of the physician's complex task in difficult cases.

Learning from Peers: case-discussion offers a

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**A fuller discussion of this subject, emphasizing step-by-step procedure and including also four model cases, may be ordered from the Illinois Council on Continuing Medical Education, 55 E. Monroe St., Suite 3510, Chicago, IL 60603—FREE to Illinois physicians (MD or D.O.) and CME sponsors. To others a charge of $2/copy is necessary to cover cost of printing, postage, and handling; payment must accompany order.*

(Continued on page 306)

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Case Discussion in CME

(Continued from page 304)

non-threatening opportunity for the individual physician to identify what he *doesn't* know and a motivation to correct deficiencies. He learns from his peers and thus avoids the personally-denigrating experience of listening to the visiting expert imply that he really doesn't know what he's doing—a phenomenon that is increasingly common as biomedical research advances further into the frontiers and quite likely to lead the physician to reject whatever he hears.[6,7]

Direct Relations to Current Problems: case discussion is based on the sound pedagogical theory, fully buttressed by research, that one learns best when the learning starts where the learner is and deals with material of immediate concern to him.[8] This is especially so when the problems selected for case-discussion are detected by medical audit or derived from systematic analysis of learning needs. Either source will produce cases common to the experience of the group. This is likely to be most often so when cases for discussion are developed by individual members of the medical staff from their own practice experience.

Should a mistake be made in choice of case so that it does not fit participants' immediate concerns, the freedom of the discussion method enables participants to shape the case material to their interests.

Basis for Evolving Criteria of Care: case-discussion planned to meet current learning needs can also help evolve criteria-of-care now required by JCAH and other authorities. The seminar need only formulate its response to the problem posed, in the form of quality-of-care criteria; these can be collected for use by the appropriate committee.

Inter-Specialty Dialogue: as medical specialization increases, so does the difficulty of bringing to bear on any single patient's problems the competence and skill of all the specialists who might help alleviate the patient's complaint. If the right cases are chosen, group discussion provides an unusual opportunity for physicians in different specialties to improve their skill in interdisciplinary dialogue and should pay off in increased consultation among different specialties within the hospital.

Identification of High Competence: no CME program can be successful if its intent is to single out the "scoundrels" or to reward the most competent; on the contrary, in-hospital continuing education must aim to help those most in need. Yet with increasing demand for accountability, every physician organization needs some method by which to identify those with both leadership ability and strong clinical competence. Problem-solving case-discussion, emphasizing learner participation, offers one means to identify the best clinicians.[9]

Disadvantages of Case-Discussion

Time Consumption: a good case-discussion session, even for a small group, requires more time than formal presentations. Most physicians are well-trained in absorbing information; hence, when the learning problem at hand involves the rapid acquisition of *facts,* other learning methods are more efficient: reading, lectures, formal courses.

Lack of Skill in Discussion: most physicians are not trained to participate well in group discussion; further, the mis-use of discussion techniques by zealous enthusiasts of group process has persuaded many scientifically-oriented professionals, including physicians, that the method is useless. These attitudes are by no means an insuperable barrier; initially some physicians will be hesitant, but most take to case discussion with enthusiasm.

Limitations: group discussion is of little use in improving manipulative skills, although *group activity* frequently reinforces individual learning efforts.

What Happens in Case-Discussion

Many physicians hesitate to use the case-discussion method because it is unfamiliar and still relatively rare in medical education at any level, although it is increasingly the major modality during the clinical years of medical school and internship/residency programs.

The *first* time a hospital uses it, it is usually better *not* to announce "case discussion" ahead of time, lest too many stay away from the scheduled CME session, for the same reason CME planners might hesitate to try it. Announce instead the *goal* to be attained, *e.g.,* "Better Care of Hypertensive Patients."

When people arrive for the scheduled meeting, these reactions are likely to be encountered: Some will begin to feel uncomfortable when they discover that their "lecture" room is not set up with rows of seats, podium, projector and screen, because of uncertainty about what is going to transpire. When they see the written case and accompanying questions, some will fear they are about to have an examination, a source of possible embarassment that can cause extreme apprehension. A few will walk out, and others may not even enter the room.

Of those who remain, some will sit alone rather than at a Team table; they should be encouraged to join other people. After the program is introduced and the ground rules explained, individual participation will quickly blossom as participants become interested. Discussion usually will begin spontaneously at one or two tables, usually those with a strong leader; hearing these voices in turn encourages other tables to begin discussion—a chain reaction. In some teams one member may dominate, or there may be confrontation because of differences in viewpoint; some participants who are less aggressive or short on knowledge will sit passively and observe the whole session, simply not participating in any visible way (although they may be strongly involved internally).

Almost without exception, each four-person Team can reach a consensus of opinion regarding all aspects of a case-problem, even if compromise is necessary. In turn, the requirement that each Team select a single solution stimulates thinking that usually leads to honestly-frank disagreement when individual Teams report their respective conclusions to the larger Group—further stimulation for individual physicians to think on their own patient-problems.

Other Features of Effective Case-Discussion

Present Case in Writing: include all facts related to the clinical problem offered for solution, including also relevant personal and social data, plus any other facts needed to solve the problem (charts, graphs, anatomical drawings or photographs, EKG or EEG tracing, *etc.*). It is also useful to conclude the case-presentation with a set of questions that lead discussants logically through an analysis of the case.

Individual Work: begin each case-discussion by having each participant work through the case alone, developing his own response to the problem presented.[10,11] He/she is then better prepared to engage in constructive team discussion.

Handout: prepare a handout containing the possible solution (s) to the problem for distribution at the end of the session. If possible, add a brief bibliography of pertinent books, recent articles, and monographs, to aid follow-up study by interested individuals.

Use of Moderator: it is useful, but not always necessary, to have an expert on the subject serve as Group moderator. In contrast to usual procedure, he/she should speak as little as possible until the final few minutes, when appropriate comments on the Group's decisions or a systematic analysis of the problem or suggestions for other approaches to the disease entity or patient-problem can be offered.

Avoid audio-visual aids: these usually detract from the primary goal of audience participation. If any are necessary, to the extent possible reproduce them with the case-study or provide them with the final hand-out.

Binder: For on-going case-discussion CME programs, a standard three-ring binder for each participant is convenient for future reference. A set of dividers labeled by subject-area will help keep the material in order.

Conclusion

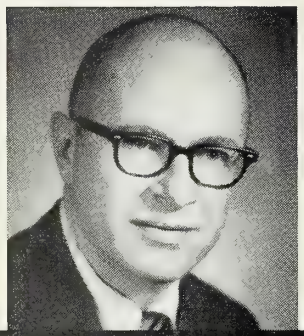
As for every other learning method, there are no secrets to success with case-discussion, despite the special advantages of the discussion method for sophisticated professionals. Case-discussion can work; it can also be a dismal failure. This paper suggests *one* approach; when a hospital staff becomes comfortable with the basic method, a wide range of variations are likely to emerge in response to particular local interests, needs, and style. ◄

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Opinion & Dialogue

Should a specially prepared package insert be made available to patients?



Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration



Dr. James H. Sammons
Executive Vice President
of the American
Medical Association

The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

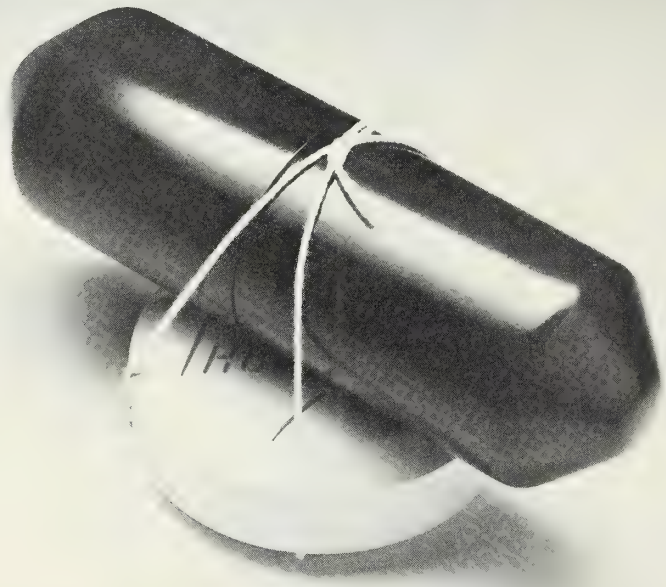
I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

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When given together, initial dosage of both agents should be reduced. 'Lasix' is a potent diuretic, and 'Dyrenium' has an additive effect, so careful supervision and dosage adjustment is required. K^+ supplements should not be given unless dosage adjustment fails to reduce excessive potassium loss, hypokalemia develops, or dietary intake of K^+ is markedly reduced. Hyperkalemia can occur, but it is rare in patients with normal renal function. The elderly, diabetics, or patients with suspected or confirmed renal insufficiency should be observed closely; check serum K^+, BUN, and CO_2 periodically.

†**'Lasix' is contraindicated in women of child-bearing potential, anuria, increasing azotemia and oliguria, hepatic coma or electrolyte depletion, hypersensitivity to the drug, and pediatric patients. Initiation of therapy in patients with hepatic cirrhosis and ascites is best carried out in the hospital. Before prescribing, see complete prescribing information in Hoechst-Roussel literature or *PDR*.**

See facing page for 'Dyrenium' indications and brief summary of prescribing information.

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***Indications: Edema associated with congestive heart failure, cirrhosis and nephrotic syndrome; steroid induced edema, idiopathic edema, edema due to secondary hyperaldosteronism and edema resistant to other diuretic therapy.**

Contraindications: Severe or progressive kidney disease or dysfunction (possible exception: nephrosis). Severe hepatic disease. Pre-existing elevated serum potassium. Hypersensitivity to the drug. Continued use in developing hyperkalemia. Do not give potassium supplements, either by drug or by diet.

Warnings: Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported. Check BUN and serum potassium periodically, especially in the elderly, diabetics, and those with suspected or confirmed renal insufficiency. Use in pregnancy only when essential to patient welfare.

Dyrenium (triamterene, SK&F) and spironolactone are not usually used concurrently; if they are, however, frequent serum potassium determinations are required.

Precautions: If hyperkalemia develops, withdraw the drug. The following may also occur: electrolyte imbalance, low-salt syndrome (with low salt intake), reversible mild nitrogen retention, decreasing alkali reserve with possible metabolic acidosis. Do periodic hematologic studies in cirrhotics with splenomegaly. Concomitant use with antihypertensive drugs may result in an additive hypotensive effect. When 'Dyrenium' is to be discontinued after intensive or prolonged therapy, withdraw gradually because of possible rebound kaliuresis.

Adverse Reactions: Diarrhea, nausea and vomiting (may indicate electrolyte imbalance), other gastrointestinal disturbances, weakness, headache, dry mouth, anaphylaxis, photosensitivity, elevated uric acid, rash.
Note: When combined with another diuretic, the initial dosage of each agent should be lower than recommended.

Supplied: 50 and 100 mg. capsules, in bottles of 100 and in Single Unit Packages of 100 (intended for institutional use only).

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Doctor's Aren't the Only Ones with Problems

In a recent appearance on the "What's the Issue?" weekly radio program produced by the National Chamber, Dr. Murray L. Weidenbaum, author of the new paperback, GOVERNMENT-MANDATED PRICE INCREASES, was asked to cite an example of the confusion and contradictions often encountered in government regulatory policies.

Here is the example he chose:

> "If I had to choose a favorite it would be the housewife in New York State who really has a quandary because there is no way she can wash her children's pajamas legally, because the Federal Government, for good reason, has required the manufacturers of pajamas for children to put on fire-resistant properties so the kids don't burn up. Fine.
>
> "New York State, like many other states, has banned phosphates in detergents because they don't want to pollute the water. That's also a good objective. But to my knowledge there's no way of washing pajamas in non-phosphate detergents without washing away the fire-resistant quality.
>
> "What does a housewife do who is concerned both about ecology and her child? Does she smuggle in some phosphate detergents? Does she commit an illegal act of laundry? Literally, that's what the government has gotten her to do. There's no way she can obey both regulations because they are in direct conflict."

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Editorials

Routine Chest X-rays: Phase-Out Time?

Forty years ago, Dr. Irving S. Cutter, then medical director of Passavant Memorial Hospital, was asked by the medical department to have routine chest X-rays on all new admissions. He turned down the request because, in his opinion, it would increase hospital care costs, and was likely to engender requests for other routine laboratory tests.

And, as I recall, Passavant was already doing routine serological and urine tests and complete blood counts. Dr. Cutter also felt that the yield of pathology from routine chest X-rays would be too small, considering the cost.

In 1970 more than 70 million chest X-rays were done in the United States at an estimated cost of nearly 1½ billion dollars. The State pays for some, and we individuals pay the rest.

Sagel and his colleagues published the results of over 10,000 posteroanterior (PA) and lateral chest X-rays. Six thousand of these X-rays were routine screenings done when the patient entered the hospital or as a preliminary to surgery. In 15% the routine chest X-ray was done because a serious abnormality was suspected. Twenty-six per cent of these patients were over the age of 40, and when their medical history was reviewed, the percentage of suspected abnormalities fell to four. The commonest condition suspected was cardiomegaly, followed by obstructive pulmonary disease. Yet, these conditions, especially obstructive pulmonary disease, are better diagnosed by other means.

Sagel concluded that when there is no clinical reason to suspect chest disease, routine radiography is unproductive below the age of 20. Between the ages of 20 and 40, a routine PA chest X-ray is adequate. Routine PA and lateral studies are justified in patients, regardless of age, when chest disease is a possibility. The same applies to patients over 40 who are entitled to routine PA and lateral films.

Ostensibly, we have overestimated the value of mass miniature radiography (M.M.R.) in lowering the risk of infection by tuberculosis. Experienced radiologists have missed as many as 25% of active tuberculous lesions using 70 mm. films. The lesions were later diagnosed on conventional large film. Since M.M.R. is also a costly way to screen for tuberculosis, it has been discontinued in many areas. In addition, it exposes the individual to relatively high doses of radiation (around 20 times that obtained with the larger film).

Routine chest X-rays are no longer advised in pregnant women who are free of respiratory symptoms. Exceptions are certain categories of pregnant women—immigrants, diabetics, those with a history of tuberculosis or recent contact, and those living in bad home conditions. Obviously an X-ray is critical in patients with recent tuberculin conversion or a large reaction to the tuberculin test.

The routine chest X-ray has been especially disappointing in detecting curable lung cancer.

T. R. Van Dellen, M.D.
Editor

Reference

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INDICATIONS: For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset of action is somewhat slower than that of nitroglycerin.

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Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilatation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

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Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

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American Association of Medical Assistants — Illinois Chapter

Certification—Why?

By Janet Konrad, CMA-AC and Judith Miller, CMA-AC

Much like physicians who sit for Board examinations, medical assistants are offered the opportunity to sit for a certifying examination attesting to their level of competence.

The American Association of Medical Assistant's Certifying Board, since its inception in 1961, has offered a certification program. The purposes of this program which are 1) to establish professional standards and goals for medical assistants; 2) to help physicians identify competent medical assistants; 3) to prepare and distribute complete information concerning the Certifying Examination; 4) to prepare and administer an annual Certification Examination and specialty examinations in Administrative, Clinical and Pediatric categories; and 5) to certify those who successfully complete the examination.

The examination is a one-day examination offered in over seventy-two test centers throughout the nation. After January, 1976, the examination will be offered twice a year. To date there are 3003 Certificed Medical Assistants.

The Certification Examination* consists of questions covering the following areas: medical terminology, basic anatomy and physiology; psychology-human relations, patient contact; medical ethics, law and economics; administrative procedures, and clinical procedures. In addition, three specialty examinations are offered: Administrative, Clinical and Pediatrics. Prospects for other specialty examinations are on the horizon.

Candidates for the Certification Examination are required to pass the entire examination in one attempt. If a candidate is succesful, a Certified Medical Assistant certificate will be issued. The CMA pin, a distinctive complement to the medical assistant's uniform, indicates the area or areas of certification.

If a candidate for the Certification Examination is not successful on the first attempt, the entire examination may be repeated in any of the three subsequent examination periods upon reapplication and payment of the examination fee. Applicants for the Certification Examination may apply for one specialty examination at the same time. However, the applicant must pass the Certification Examination before specialty certification will be granted.

A "Mini-Test" (simulated examination) has been developed to answer some of the questions about the Certification Examination and to encourage more medical assistants to take it. The Mini-Test is about one-fifth the length of the Certification Examination and consists of questions used in previous examinations or their equivalent. The Mini-Test is administered at AAMA national conventions, state conventions, or through the local chapters of AAMA.

Before asking ourselves WHY we should obtain certification, perhaps it would serve as some enlightenment to explain the spirit of certification. The American Association of Medical Assistants, in setting up a Certification Examination, has established high standards of achievement for the medical assistant. To obtain certification the medical assistant must not only be knowledgeable about a wide variety of medically-related topics, but must also be skillful in interpersonal relations with the patient, physician and coworkers, as well as alert to medico-legal implications within these relationships. The most valuable medical assistant is one who can skillfully apply knowledge practically. The essence of certification, then, is quality patient care, a prime objective of physician and allied health worker alike.

Through certification, we not only elicit the trust of our physician and his patients, but we also begin to realize our own potentials. It signifies the meeting and exceeding of the high standards of the professional medical assistant, designated by the title Certified Medical Assistant.

A medical assistant who receives certification must accept responsibility for maintaining quality and excellence within the field, promote other individuals' understanding of the value of certification, actively assist in the educational advancement of others, and elevate and promote the professionalism of the medical assisting field. The CMA's responsibility to self, of parallel importance to the above objectives, must then be intensified. Medicine is constantly advancing and keeping up with its pace is the medical assistant's responsibility.

**Further information regarding the Certification Examination may be obtained by writing the American Association of Medical Assistants, Inc., Chairman, Certifying Board, One East Wacker Drive, Chicago, Illinois 60601.*



Medical Story

The "Housestaff News" is designed for interns and residents. News items and short articles of interest to housestaff will be considered for publication; materials should be sent to Michael Hughey, M.D., 711 Laurel Avenue, Wilmette, Ill. 60091.

Early in September, NBC aired a television show entitled "Medical Story" which caused considerable discussion among the housestaff and attending physicians at many hospitals, my own included. The two-hour pilot program portrayed the case of a woman who died of a pulmonary embolus following an "unnecessary" hysterectomy. The "hero" was a young intern, pitted against the older gynecologist who also happened to be one of the founders of the hospital. In the end, everyone lost, the patient, the intern and the physician.

Although the show was advertised as portraying real-life situations, the factual inaccuracies were appalling to many physicians who watched the show. Some housestaff condemned the woefully inadequate treatment of pulmonary embolism, oxygen and intravenous fluids being conspicuously absent. Our attending physicians made sharp remarks about the misinformation the program presented as factual, (e.g., "the only indications for hysterectomy are malignancy and infection.") Many interns were amazed at the depth of experience the hero, an intern, achieved over the course of several days. He participated in deliveries, hysterectomies, general surgery, pediatrics, internal medicine, emergency medicine, and a distinctly alcoholic party held in what appeared to be an operating room.

Although factual inaccuracies should come as no surprise to anyone familiar with the fictional side of television broadcasting, the response to this program by many members of our staff was both sharp and emotional. The comments it provoked bordered on either side of vulgarity. Nonetheless, for all of its shortcomings, the show did point out at least one item of value to housestaff and attending physicians alike, the importance of communication.

Neither of the two lead characters in the show listened to what the other was saying. The intern tried several times to question both the diagnosis and therapeutic regimen of the attending physician, but the attending physician would not listen. At other times, the attending physician tried to explain why he had chosen that particular therapeutic regimen, but the intern, too preoccupied with his own ideas, did not listen. Most of the attempts at communicating were through yelling and, in general, the louder a person yells, the harder it is to hear him.

Interns and other housestaff would do well to listen more carefully to what their attending physicians tell them. Physicians in practice have a peculiar insight into medicine that only years of experience and close knowledge of the patient can bring. Every physician in practice has been in precisely the same situation as the new intern, and because of that experience can anticipate many of the questions the intern may ask. Having lived through the housestaff experience, most attending physicians have considerable insight into and sympathy for the housestaff physician's attitude. They have many valuable things to teach, but the housestaff physician must listen if these things are to be learned.

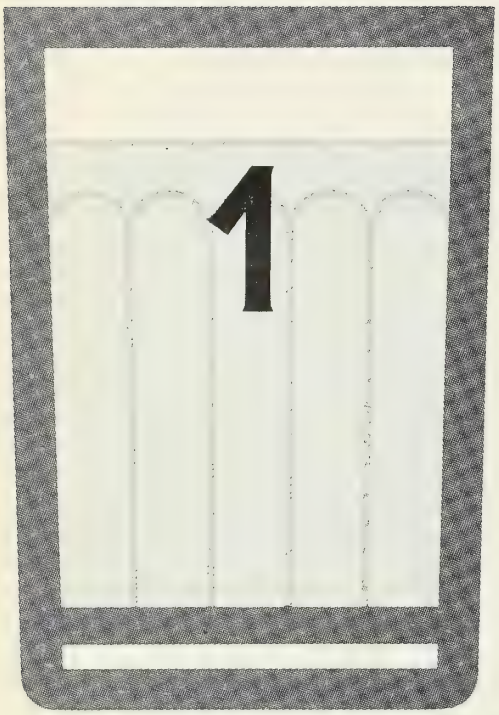
Likewise, attending physicians would do well to listen carefully to their housestaff. What the housestaff physician lacks in years of clinical experience, he makes up in zeal, recent exposure to the latest diagnostic and therapeutic techniques, and an intense, hour-by-hour personal involvement with the patient in the hospital. It is well known that patients may tell one doctor one thing, and another doctor something entirely different. These differences need to be communicated for they very often have a profound effect on the management of the patient's problem.

Communication doesn't mean writing a note in the chart, or speaking a few words to someone. Communication means the conveyance of an idea from one person to another. Three different people can say exactly the same thing, and perhaps only one of them will be heard. The first person might be yelling so loud that no one can hear him. The second person might speak with such an antagonistic tone of voice that no one wants to hear him. The third person might speak with a calm voice, stating the facts without implying that the person listening to him is stupid or worse. It is the third person who will be heard.

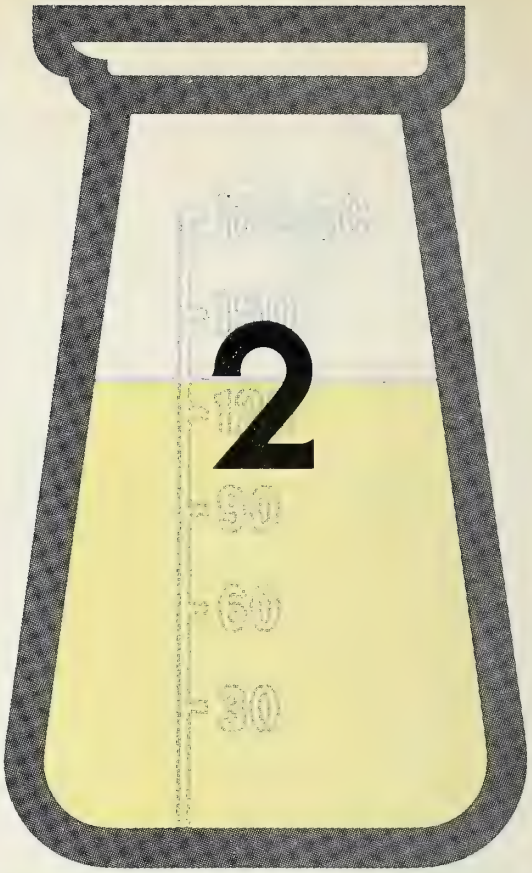
The same three people might write their comments in a patient's chart, but only one of the comments will be heard. The first person's handwriting is so poor that no one can read what he says. The second person's note is filled with sarcasm and self-importance that in more-or-less polite terms tells the person reading the note that he is a dummy. The person reading that note won't listen to it, he'll merely react like a human being and begin to plan his answer to the note. It will be the third person who communicates with a clearly written, unemotional note that is concise and to the point. Other physicians will read and understand the third person's note.

Communication with the patient is equally important. The "gall bladder in room 2302" can't talk, but the patient with pain in his abdomen can. All the gall bladder in 2302 can say is that it has stones in it. It can't say that the pain is coming from there, any more than it can say that its neighbor, the pancreas, is inflamed. But the patient can tell you all of these things, not in those terms, but by a careful, well-communicated history. If no one listens to the patient, only to his gall bladder, many mistakes will be made.

"Medical Story" has come and gone, and probably no permanent harm will result from it. Tempers have long since cooled, and most of us are back at work taking care of patients. But perhaps one small lesson in communication has been learned. Every one of us, housestaff and attending physicians alike, must try diligently to listen to the patient and to each other. Without this communication, most patients will probably still get better, but they will have received second class and not first class care. ◄

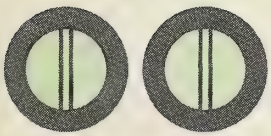


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Indications: Acute, recurrent or chronic non-obstructed urinary tract infections (primarily pyelonephritis, pyelitis, and cystitis) due to susceptible organisms. ***Note:*** **Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials, including sulfonamides, especially in chronic or recurrent urinary tract infections.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

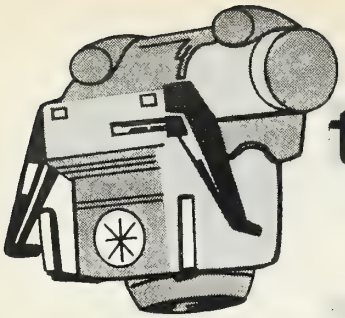
Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

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the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine



Fig. 1



Fig. 2

This 70-year-old female fell on her knee. The knee was markedly swollen. A routine AP and lateral of the knee (Figure 1) failed to disclose any evidence of fracture. Because of the marked soft tissue swelling a translateral film of the knee was taken (Figure 2) and demonstrated a fat fluid level immediately above the patella. Because of this an additional film was taken (Figure 3) and an intracondylar fracture of the femur was demonstrated which had not been previously visualized. The fat fluid level sign (chicken soup sign) is helpful in cases particularly about the knee joint where fat escapes from the bone marrow into the joint and layers out on a dependent film. In order to demonstrate the intracapsular fat, the lateral view is made with the horizontal beam while the patient lies supine permitting the fat to float on the water density blood.

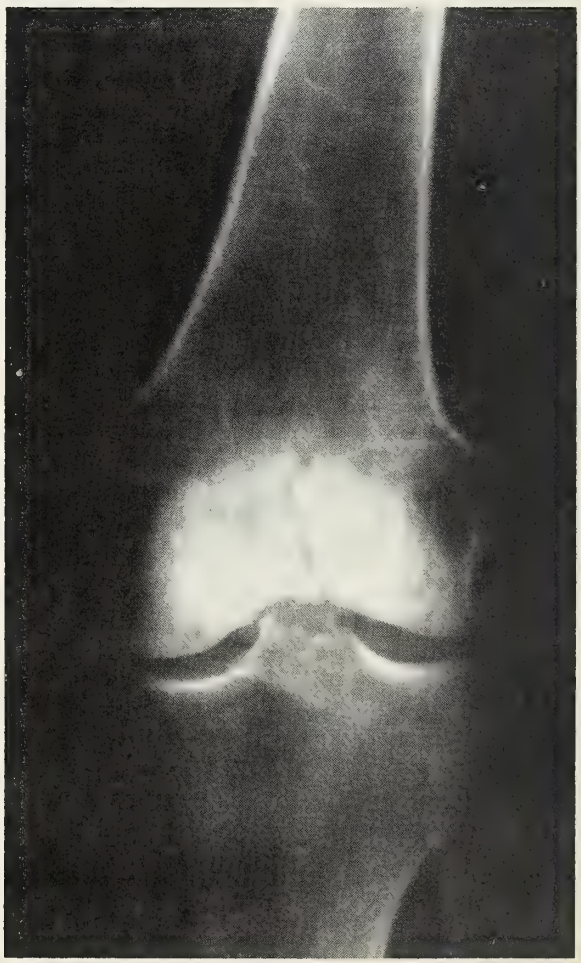


Fig. 3

They are Still Crying

By John G. Raffensperger, M.D./Chicago

Dr. Willis Potts, the late Surgeon-in-Chief of the Children's Memorial Hospital wrote,

> *"With no language but a cry, children are asking for better surgical treatment of their ills and are begging for more thoughtful attention to the congenital deformities it was their misfortune to be born with. The newborn infant has no words to demand his rights and is aided only by a couple of flustered parents dismayed at the sudden misfortune of an unanticipated catastrophy."*[1]

This was written fifteen years ago; unfortunately, they are still crying.

In our state, at large city institutions as well as in suburban and rural general hospitals, many excellent physicians and surgeons provide optimum care for adults. In part this excellence is due to our many fine medical schools and teaching hospitals in Illinois which produce these doctors.

At one time pediatricians and surgeons were expected to care for the unusual infant who came along with an intestinal obstruction or imperforate anus as well as the more common lesions of childhood, in their own hospitals. With the declining birth rate any one surgeon or even a group of surgeons in a general hospital has little opportunity to do enough pediatric work to keep abreast of the many advances in this field.

At this time in a children's center with a team of pediatricians, pediatric surgeons, radiologists, pathologists, anesthesiologists and nurses who are totally dedicated to the care of children, infants who are born with birth defects such as tracheoesophageal fistula or intestinal obstruction should look forward to a 100% survival. A dedicated pediatric medical and surgical house staff is indispensable to care for these babies 24 hours a day. This includes taking care of their intravenous fluids, medications, and an assortment of gastric, chest and urinary tubes.

Unfortunately, nearly every week despairing parents bring in babies who have been operated upon for birth defects. Many of these infants continue to suffer from their original problem in addition to the complications of misguided surgery. Weeks and often months of intravenous nutritional support and further operations are then necessary to restore these infants to health.

Expert pediatric radiologists and pathologists are essential in the management of the tumors of childhood and Hirschsprung's disease. These lesions are quite different from anything encountered in adult practice in a general hospital and are difficult for an expert pediatric specialist let alone a man who may see only one such case in five years.

I am sorry to say that even the more common lesions such as hernias, pyloric stenosis and intussusceptions do not always receive optimum care in general hospitals. Within the past three years I have seen five children who were at death's door from iatrogenic complications of appendicitis. I occasionally hear of babies with pyloric stenosis who have had a cardiac arrest under anesthesia for surgery in an outlying hospital. I also recently saw an infant who had a gangrenous midgut volvulous because of a misplaced incision for a pyloric stenosis. Furthermore, there are far too many boys who have ugly, oblique scars, atrophic testicles and recurrent hernias because their original simple congenital hernia had been repaired by an adult technique.

With todays excellent transportation system there is no reason why every pediatric surgical emergency cannot be transferred to a children's medical center. Furthermore, well trained pediatric surgeons are no longer the oddities they were fifteen years ago when Dr. Potts wrote "The Surgeon and the Child."

There isn't a credentials committee in Illinois who would allow a physician, who had performed two or three cholecystectomies in his life time, tackle a difficult common duct exploration. Why then should some surgeons operate on these exceedingly rare, difficult pediatric problems when these infants can be given a much better opportunity for life in a center devoted to the care of children. ◄

JOHN G. RAFFENSPERGER, M.D., is head of the Division of General Surgery, Pediatric Surgery at Children's Memorial Hospital and a Consultant in Pediatric Surgery at Mt. Sinai Hospital and Illinois Research Hospital. He is also Associate Professor of Surgery at Northwestern University Medical School.



Reference

1. The Surgeon and the Child, Willis Potts, M.D., W. B. Saunders & Co., 1975.

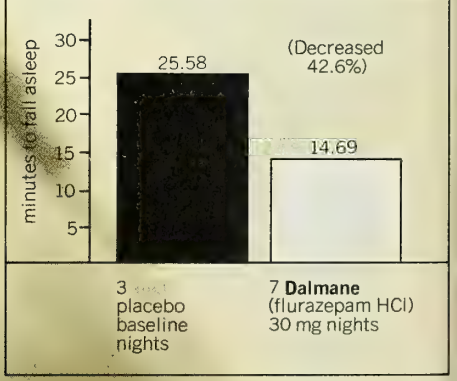


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Average Time Required to Fall Asleep [1-4]
(Four Geographically Separated Sleep Research Laboratory Clinical Studies, 16 Subjects)



IMJ
Illinois Medical Journal
Vol. 148, No. 4, October, 1975

ISMS ORGANIZATION

History of Founding and Expansion

Twenty-nine physicians met in Springfield June 4, 1850, to organize on a permanent basis the Illinois State Medical Society, which had been started informally 10 years earlier. The founders were concerned with the solution of ethical, scientific, legislative and economic problems. The first Constitution and Bylaws and the first Code of Medical Ethics were adopted; the first legislative committee was appointed, and a resolution outlining the beginnings of interprofessional relations was approved.

The Legislative Committee was instructed to "memorialize the legislature at its next session, praying the enactment of a statute providing for the registration of Births, Deaths and Marriages." The resolution ruled that "members of the Society will discourage the sale of patent or secret nostrums on the part of Druggists and Apothecaries throughout the State, and will patronize insofar as practicable, only those who abstain from the sale of such patent or secret nostrums."

The first full time secretary of the Society was Dr. Harold M. Camp who served for over 35 years until his death in 1959. The first executive administrator, Robert L. Richards, was employed at the time the office was moved to Chicago in 1960 and served until February, 1966. After an interim service by Dr. George F. Lull, Mr. Roger N. White was selected as Executive Administrator in May, 1968.

The Society published the early transactions in book form presenting not only the minutes of the House of Delegates, but also all scientific papers given at each annual convention. In 1899 a new era of communications began, for at that time, the *Illinois Medical Journal* was established and became the first "official organ of the Society."

Dr. G. N. Kreider was its first editor and served until 1913, followed by Dr. Clyde D. Pence with Dr. Henry G. Olds as the first managing editor. Dr. Charles G. Whalen became editor in 1919 and he and Dr. Olds served until they died in 1940. Dr. Camp followed Dr. Whalen, and Dr. Theodore R. Van Dellen is the editor today.

Dr. Whalen spearheaded many important activities in medicine, and has been called "the outstanding champion of the medical profession in its economic contacts.' He has been credited as one of the first medical editors to blast "the socialization of medicine in this country." In 1922 he wrote extensively on state medicine, workmen's compensation, compulsory health insurance, free hospitalization and federal aid.

The first Fifty Year Club in the United States was announced by the *Illinois Medical Journal* in 1938.

The fourth largest medical society in the country has developed from these embryonic beginnings. This edition of the *Illinois Medical Journal* offers you an opportunity to contrast the extensive services available to the membership today with those offered in the past.

OFFICERS AND PLACES OF MEETING

Year	President	Secretary	Treasurer	Mtg. Place
1840	John Todd	David Prince		Springfield
1850	Rudolph Rouse	Edwin G. Meek		Springfield
1850	William B. Herrick	Edwin G. Meek	Jno. Halderman	Springfield
1851	Samuel Thompson	H. Shoemaker	R. Rouse	Peoria
1852	Rudolph Rouse	E. S. Cooper	Edw. Dickenson	Jacksonville
1853	Daniel Brainerd	H. A. Johnson	A. B. Chambers	Chicago
1854	C. N. Andrews	H. A. Johnson	N. S. Davis	LaSalle
1855	N. S. Davis	E. Andrews	J. V. Z. Blaney	Bloomington
1856	H. Noble	N. S. Davis	J. V. Z. Blaney	Vandalia
1857	C. Goodbreak	H. A. Johnson	J. V. Z. Blaney	Chicago
1858	H. A. Johnson	N. S. Davis	J. W. Freer	Rockford
1859	David Prince	N. S. Davis	J. W. Freer	Decatur
1860	Wm. M. Chambers	N. S. Davis	J. W. Freer	Paris
1863	A. McFarland	N. S. Davis	J. H. Hollister	Jacksonville
1864	A. H. Luce	N. S. Davis	J. H. Hollister	Chicago
1865	J. M. Steele	N. S. Davis	J. H. Hollister	Bloomington
1866	F. F. Haller	N. S. Davis	J. H. Hollister	Decatur
1867	H. Noble	N. S. Davis	J. H. Hollister	Springfield
1868	S. T. Trowbridge	N. S. Davis	J. H. Hollister	Quincy
1869	S. T. Trowbridge	T. D. Fitch	J. H. Hollister	Chicago
1870	J. V. Z. Blaney	T. D. Fitch	J. H. Hollister	Dixon
1871	G. W. Albin	T. D. Fitch	J. H. Hollister	Peoria
1872	J. O. Hamilton	T. D. Fitch	J. H. Hollister	Rock Island
1873	D. W. Young	T. D. Fitch	J. H. Hollister	Bloomington
1874	T. F. Worrell	T. D. Fitch	J. H. Hollister	Chicago
1875	J. H. Hollister	T. D. Fitch	Wm. E. Quine	Jacksonville
1876	T. D. Washburn	N. S. Davis	J. H. Hollister	Urbana
1877	T. D. Fitch	N. S. Davis	J. H. Hollister	Chicago
1878	J. L. White	N. S. Davis	J. H. Hollister	Springfield
1879	E. P. Cook	N. S. Davis	J. H. Hollister	Lincoln
1880	Ephraim Ingalls	N. S. Davis	J. H. Hollister	Belleville
1881	G. W. Jones	S. J. Jones	J. H. Hollister	Chicago
1882	Robert Boal	S. J. Jones	J. H. Hollister	Quincy
1883	A. T. Darrah	S. J. Jones	J. H. Hollister	Peoria
1884	E. Andrews	S. J. Jones	Walter Hay	Chicago
1885	D. S. Booth	S. J. Jones	Walter Hay	Springfield
1886	Wm. A. Byrd	S. J. Jones	Walter Hay	Bloomington
1887	Wm. T. Kirk	D. W. Graham	Walter Hay	Chicago
1888	Wm. O. Ensign	D. W. Graham	Walter Hay	Rock Island
1889	C. W. Earle	D. W. Graham	T. W. McIlvaine	Jacksonville
1889	John Wright	D. W. Graham	T. W. McIlvaine	Chicago
1891	Jno. P. Mathews	D. W. Graham	Geo. N. Kreider	Springfield
1892	Charles C. Hunt	D. W. Graham	Geo. N. Kreider	Vandalia
1893	E. Fletcher Ingals	D. W. Graham	Geo. N. Kreider	Chicago
1894	Otho B. Will	J. B. Hamilton	Geo. N. Kreider	Decatur
1895	Daniel R. Brower	J. B. Hamilton	Geo. N. Kreider	Springfield
1896	D. W. Graham	J. B. Hamilton	Geo. N. Kreider	Ottawa
1897	A. C. Corr	J. B. Hamilton	Geo. N. Kreider	East St. Louis
1898	J. N. G. Carter	E. W. Weis	Geo. N. Kreider	Galesburg
1899	J. T. Pitner	E. W. Weis	Geo. N. Kreider	Cairo
1900	H. N. Moyer	E. W. Weis	Geo. N. Kreider	Springfield
1901	G. N. Kreider	E. W. Weis	E. J. Brown	Peoria
1902	J. T. McAnally	E. W. Weis	E. J. Brown	Quincy
1903	M. L. Harris	E. W. Weis	E. J. Brown	Chicago
1904	C. E. Black	E. W. Weis	E. J. Brown	Bloomington
1905	W. E. Quine	E. W. Weis	E. J. Brown	Rock Island
1906	H. C. Mitchell	E. W. Weis	E. J. Brown	Springfield
1907	J. F. Percy	E. W. Weis	E. J. Brown	Rockford
1908	W. L. Baum	E. W. Weis	E. J. Brown	Peoria
1909	J. W. Pettit	E. W. Weis	E. J. Brown	Quincy
1910	J. L. Wiggins	E. W. Weis	E. J. Brown	Danville
1911	A. C. Cotton	E. W. Weis	E. J. Brown	Aurora
1912	W. K. Newcomb	E. W. Weis	E. J. Brown	Springfield
1913	L. H. A. Nickerson	E. W. Weis	A. J. Markley	Peoria
1914	Charles J. Whalen	W. H. Gilmore	A. J. Markley	Decatur
1915	A. L. Brittin	W. H. Gilmore	A. J. Markley	Springfield
1916	C. W. Lillie	W. H. Gilmore	A. J. Markley	Champaign
1917	W. L. Noble	W. H. Gilmore	A. J. Markley	Bloomington
1918	E. B. Coolley	W. H. Gilmore	A. J. Markley	Springfield
1919	E. W. Fiegenbaum	W. H. Gilmore	A. J. Markley	Peoria
1920	J. W. Van Derslice	W. H. Gilmore	A. J. Markley	Rockford
1921	W. F. Grinstead	W. H. Gilmore	A. J. Markley	Springfield
1922	Charles Humiston	W. H. Gilmore	A. J. Markley	Chicago
1923	E. P. Sloan	W. D. Chapman	A. J. Markley	Decatur
1924	E. H. Ochsner	W. D. Chapman	A. J. Markley	Springfield
1925	L. C. Taylor	H. M. Camp	A. J. Markley	Quincy
1926	J. C. Krafft	H. M. Camp	A. J. Markley	Champaign
1927	Mather Pfeiffenberger	H. M. Camp	A. J. Markley	Moline
1928	G. Henry Mundt	H. M. Camp	A. J. Markley	Chicago
1929	J. E. Tuite	H. M. Camp	A. J. Markley	Peoria
1930	F. O. Frederickson	H. M. Camp	A. J. Markley	Joliet
1931	Wm. D. Chapman	H. M. Camp	A. J. Markley	East St. Louis
1932	R. R. Ferguson	H. M. Camp	A. J. Markley	Springfield
1933	John R. Neal	H. M. Camp	A. J. Markley	Peoria
1934	Philip H. Kreuscher	H. M. Camp	A. J. Markley	Springfield
1935	Charles D. Center*			
1935	Charles S. Skaggs	H. M. Camp	A. J. Markley	Rockford
1936	Chas. B. Reed	H. M. Camp	A. J. Markley	Springfield
1937	Rolland L. Green	H. M. Camp	A. J. Markley	Peoria
1938	R. K. Packard	H. M. Camp	A. J. Markley	Springfield
1939	S. E. Munson	H. M. Camp	A. J. Markley	Rockford

(Continued on following page)

Year	President	Secretary	Treasurer	Mtg. Place
1940	Jas. H. Hutton	H. M. Camp	A. J. Markley	Peoria
1941	J. S. Templeton	H. M. Camp	A. J. Markley	Chicago
1942	Chas. H. Phifer	H. M. Camp	H. M. Camp	Springfield
1943	E. H. Weld	H. M. Camp	H. M. Camp	Chicago
1944	G. W. Post**	H. M. Camp	H. M. Camp	Chicago
1945	E. P. Coleman	H. M. Camp	H. M. Camp	***
1946	E. P. Coleman	H. M. Camp	H. M. Camp	Chicago
1947	R. S. Berghoff	H. M. Camp	H. M. Camp	Chicago
1948	I. H. Neece	H. M. Camp	H. M. Camp	Chicago
1949	Percy E. Hopkins	H. M. Camp	H. M. Camp	Chicago
1950	Walter Stevenson	H. M. Camp	H. M. Camp	Springfield
1951	Harry M. Hedge	H. M. Camp	H. M. Camp	Chicago
1952	C. Paul White	H. M. Camp	H. M. Camp	Chicago
1953	Leo P. A. Sweeney	H. M. Camp	H. M. Camp	Chicago
1954	Willis I. Lewis	H. M. Camp	H. M. Camp	Chicago
1955	Arkell M. Vaughn	H. M. Camp	H. M. Camp	Chicago
1956	F. Garm Norbury	H. M. Camp	H. M. Camp	Chicago
1957	F. Lee Stone	H. M. Camp	H. M. Camp	Chicago
1958	Lester S. Reavley	H. M. Camp	H. M. Camp	Chicago
1959	Raleigh C. Oldfield	H. M. Camp	H. M. Camp	Chicago
1960	Joseph T. O'Neill	George F. Lull	George F. Lull	Chicago
1961	H. Close Hesseltine	Jacob E. Reisch	Jacob E. Reisch	Chicago
1962	Edwin S. Hamilton	Jacob E. Reisch	Jacob E. Reisch	Chicago
1963	George F. Lull	Jacob E. Reisch	Jacob E. Reisch	Chicago
1964	Harlan English	Jacob E. Reisch	Jacob E. Reisch	Chicago
1965	Edward A. Piszczek	Jacob E. Reisch	Jacob E. Reisch	Chicago
1966	Burtis E. Montgomery	Jacob E. Reisch	Jacob E. Reisch	Chicago
1967	Caesar Portes	Jacob E. Reisch	Jacob E. Reisch	Chicago
1968	Newton DuPuy	Jacob E. Reisch	Jacob E. Reisch	Chicago
1969	Philip G. Thomsen	Jacob E. Reisch	Jacob E. Reisch	Chicago
1970	Edward W. Cannady	Jacob E. Reisch	Jacob E. Reisch	Chicago
1971	J. Ernest Breed	Jacob E. Reisch	Jacob E. Reisch	Chicago
1972	L. T. Fruin****	Jacob E. Reisch	Jacob E. Reisch	Chicago
1973	Frank J. Jirka, Jr.	Jacob E. Reisch	Jacob E. Reisch	Chicago
1974	Willard C. Scrivner	Jacob E. Reisch	Jacob E. Reisch	Chicago
1975	Fredric D. Lake	Jacob E. Reisch	Jacob E. Reisch	Chicago
1976	J. M. Ingalls	Jacob E. Reisch	Jacob E. Reisch	Chicago

**Died before induction into office*

***Died in office. Term completed by Robert S. Berghoff, First Vice President*

****Meeting cancelled 1945*

*****Died in office. Term completed by C. J. Jannings, First Vice President*

Principles Of Medical Ethics

PREAMBLE: These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

SECTION 1—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

SECTION 2—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

SECTION 3—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

SECTION 4—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

SECTION 5—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

SECTION 6—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

SECTION 7—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

SECTION 8—A physician should seek consultation upon request, in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

SECTION 9—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

SECTION 10—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

ILLINOIS STATE MEDICAL SOCIETY

Constitution And Bylaws

Adopted, 1903
As Amended, 1975

CONSTITUTION

ARTICLE I. NAME

The name and title of this organization shall be the Illinois State Medical Society.

ARTICLE II. PURPOSES OF THE SOCIETY

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

ARTICLE III. COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Society.

ARTICLE IV. COMPOSITION OF THE SOCIETY

The Society shall consist of active members and such other members as the Bylaws may provide.

ARTICLE V. HOUSE OF DELEGATES

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society.

Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws.

ARTICLE VI. OFFICERS

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, nineteen trustees and one trustee at large, and such other officers as the Bylaws may provide.

ARTICLE VII. BOARD OF TRUSTEES

The Board of Trustees, whose duties are executive and judicial, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

ARTICLE VIII. CONVENTIONS AND MEETINGS

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates and general scientific meetings which shall be open to all registered members.

ARTICLE IX. THE SEAL

This Society shall have a common seal with power to break, change or renew the same when necessary.

ARTICLE X. AMENDMENTS

The House of Delegates may amend this Constitution at any annual business meeting of the House of Delegates provided that the amendment shall have been proposed at the preceding annual business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.

BYLAWS

CHAPTER I. MEMBERSHIP

Section 1. *Members.* Members shall consist of Regular members, Associate members, Emeritus members, Retired members, Service members, Distinguished members, In-training members and Student members. Members enjoy full rights and privileges, including the right to vote and hold office and are counted in determining the strength of the Society's Delegation to the American Medical Association.

A. *Regular Members.* Regular members shall be those physicians licensed to practice medicine in all its branches in the State of Illinois, who are residents of the State of Illinois, persons of good moral character and professional standing and members of their component society.

Members in good standing moving out of Illinois may retain membership (not to exceed one year) in the Illinois State Medical Society until they are accepted into membership in the medical society of the state to which they have moved.

Physicians serving as full-time employees of the American Medical Association and other physicians licensed in one of the states or territories of the United States but not licensed in Illinois may become regular members although they are not actively engaged in the practice of medicine.

B. *Associate Members.* Associate members are physicians who hold the degree of Doctor of Medicine, who have a hospital permit to practice medicine in the State of Illinois and are members of their component medical society.

C. *Emeritus Members.* Emeritus members are those who have been regular members in good standing for thirty-five years, have reached or will have reached the age of seventy before the next fiscal year of the Society, have made written application to their component society and have been recommended by their component society for emeritus status. Such membership shall be effective January first of the year following election. Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of this Society for at least five years.

D. *Retired Members.* Retired members shall consist of those who have been regular members and who by reason of age or incapacity have retired from active practice and who upon application and recommendation from their component society have been made retired members. Retired status is not available to physicians who assume compensated positions after retiring from medical practice.

E. *Service Members.* Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively fulltime in their respective service, and thereafter if they have been retired on account of age or physical disability, shall be elected to service membership.

F. *Distinguished Members.* Physicians of Illinois or other states or foreign countries who have risen to prominence in the profession, teachers of medicine or of the sciences allied to medicine, not eligible for regular membership, or members of associated arts and sciences, who have made significant contributions to medicine may be nominated by any member of the House of Delegates and may be elected by the House at any annual convention by a two-thirds affirmative vote of those present and voting. They shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other society activities.

G. *In-Training Members.* In-training members are persons who are medical school graduates, of good moral character and professional standing and serving an internship or residency approved by the American Medical Association in the State of Illinois and are members, of a component medical society. Membership shall end at the end of the year in which training is terminated. Following this, in-training members may apply for regular membership through their component society.

H. *Student Members.* Student members are those who have been enrolled in an Illinois medical school, are of good moral character, professional and academic standing and student members of a component medical society.

Section 2. *Discrimination of Membership.* Membership in the Illinois State Medical Society shall not be denied or abridged because of color, creed, race, religion or ethnic origin.

Section 3. *Tenure and Termination.*

A. *Tenure of Membership.* The name of a physician on a properly certified roster of members of a component society which has paid its annual assessments, shall be prima facie evidence of membership in this society. The member shall retain his membership so long as he complies with the provisions of this Constitution and Bylaws and with the Principles of Medical Ethics of the American Medical Association. A member shall hold only one type of membership at any one time.

B. *Termination of Membership.* Any person who is under sentence of suspension, or expulsion from a component society shall not be entitled to any of the rights or benefits of this society nor shall he be permitted to take part in any of the proceedings until he has been reinstated. Non-payment of dues by May 1 of each year shall be grounds for termination of membership.

CHAPTER II. DUES, FUNDS AND ASSESSMENTS

Section 1. *Dues.* Annual dues may be levied by the House of Delegates on each class of membership. The amount of dues shall be recommended by the Board of Trustees and shall be fixed by the House of Delegates and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association. These shall include the annual subscription to the *Illinois Medical Journal* which shall be at least fifty percent of the regular subscription price of the *Journal*. Only Regular, Associate, In-training and Student members shall be assessed annual dues. The assessment shall be paid by the component society for its members prior to March 31 of each year.

Section 2. *Reduction and Remission of Dues.* Physicians in private practice of medicine may be given a fifty percent reduction in dues during the first year of practice, upon recommendation of their component society. Physicians approved for membership after June 30 shall pay one-half the annual dues for that year. The Board of Trustees may authorize remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association. Emeritus members, Retired members, Service members and Distinguished members are not required to pay dues.

Section 3. *Assessments and Funds.* In addition to dues, assessments may be made on dues-paying members on recommendation of the Board of Trustees and approval of the House of Delegates. Funds may be raised from publications of the Society and any other manner approved by the Board of Trustees. Funds may be appropriated by the Board of Trustees to be spent for the Society to carry on its publications, to encourage scientific investigations, and for other purposes approved by the Board of Trustees.

CHAPTER III.
EDUCATIONAL AND SCIENTIFIC PROGRAMS

Educational and scientific programs shall be provided by the Society at such times and places as recommended by the Board of Trustees and approved by the House of Delegates.

CHAPTER IV. HOUSE OF DELEGATES

Section 1. *Composition.* The voting membership of the House of Delegates shall consist of 1) delegates elected by component societies and affiliated groups, 2) the President, 3) the President-elect, 4) the Vice Presidents, 5) the Secretary-Treasurer, 6) the Speaker and Vice Speaker, and 7) Trustees. Past trustees, past presidents, past speakers, general officers of the American Medical Association, and delegates and alternate delegates from the Illinois State Medical Society to the American Medical Association may have the privilege of the floor without vote.

Section 2. *Delegates.* Each component society shall be entitled to send one of its members to the House of Delegates each year for each seventy-five members, not to include student members, and one for a major fraction thereof, but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws shall be entitled to one delegate. The number of delegates to which any component society is entitled shall be determined by the number of members of the component society on membership rolls of the Illinois State Medical Society as of December 31 of the preceding year. The term of office of a delegate shall begin January first following his election and shall be for two years, or until his successor has been elected. Component societies with only one delegate may elect for one year.

Section 3. *Affiliate Group Delegates.* The student members of the Illinois State Medical Society shall be considered a single affiliate group and shall be entitled to elect from their group, one student delegate with vote and one student alternate delegate to serve in the House of Delegates. One intern/resident delegate with vote and an alternate delegate, representing the interests of Illinois house staff, shall be nominated by the Advisory Committee to Physicians in Training pursuant to appointment by the Board of Trustees. Each delegate shall be considered as an Affiliated Group Member of the Illinois State Medical Society. The term of office shall begin January first following his election and shall be for two years, or until his successor is elected.

Section 4. *Time and Place of Meeting.* The House of Delegates shall meet annually at such time and place as it shall determine.

Section 5. *Quorum.* Fifty delegates representing no less than twenty component societies shall constitute a quorum for the transaction of business.

Section 6. *Special meetings.* Special meetings of the House of Delegates may be called by a majority of the Board of Trustees or upon petition of twenty component societies. When a special meeting is called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called.

Section 7. *Registration.* Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the President and/or the Secretary of his component society stating that the delegate or alternate has been regularly elected to the House of Delegates. A delegate or his alternate may be seated without credentials, provided he is properly identified and is certified to the secretary of the Illinois State Medical Society. Whenever a delegate or his alternate are unable to attend a particular meeting, the component society may select and certify a substitute delegate who shall have the same powers and duties as did the delegate. A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until the final adjournment of that session. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by the committee. After the alternate has been seated, he cannot be replaced for that session.

Section 8. *District Division.* The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

Section 9. *Order of Procedure.* The order of business of the House of Delegates shall be determined by the Speaker, subject to approval by the Reference Committee on Rules and Order of Business. Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

Section 10. *Privilege of the Floor.* The House of Delegates by two-thirds vote of those present and voting, may extend an invitation to address the House to any person who in its judgment might assist in its deliberations.

Section 11. *Introduction of Resolutions and Other Business.* All resolutions must be introduced by a voting member of the House. Resolutions to be printed in the handbook must be submitted nine weeks prior to the annual meeting. Resolutions to be mailed to the delegates prior to the annual meeting must be submitted to ISMS headquarters four weeks prior to the annual meeting. Resolutions submitted after the above date must be approved by the Speaker, Vice Speaker and one delegate from CMS and one from outside CMS or by a two-thirds vote of the House of Delegates before they will be considered as business of the House. Reports of committees, councils and officers requiring action must submit recommendations to the House as a resolution for action. Reports, resolutions and requests for action after the opening of the first session of the House of Delegates shall require for consideration a two-thirds affirmative vote.

CHAPTER V. ELECTION OF OFFICERS

Section 1. *Officers.* The officers of this Society shall consist of the president, president-elect, first and second vice presidents, secretary-treasurer, speaker and vice speaker, nineteen trustees and one trustee-at-large.

Section 2. *Elections.* All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote.

The majority of votes cast shall be necessary to elect.

The election of officers, delegates and alternate delegates to the AMA, shall follow the completion of action on current and old business at the final session of the House of Delegates.

Section 3. *Terms of Office.* The president-elect, vice-presidents, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years. The number of consecutive terms that may be served by a trustee is limited to three. This shall become effective July 1, 1975, and shall not have retroactive application.

The speaker and vice speaker shall not be elected for more than two consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

The president-elect shall be inducted into the office f president by the retiring president during the final ession of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elected and installed. Following his retirement as president, he shall automatically become a trustee-at-large for a term of one year.

CHAPTER VI. DUTIES OF OFFICERS

Section 1. *The President.* The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform such other duties as custom and parliamentary usage may require.

Section 2. *The President-Elect.* The President-Elect shall serve as the chairman of the Committee on Planning and Priorities.

Section 3. *The Vice Presidents.* The vice prsidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the president's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice president, the second vice president will become first vice president.

Section 4. *Successor to President-Elect.* In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual convention by election at a time recommended by the Reference Committee on Rules and Order of Business.

Section 5. *The Speaker.* The speaker, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint all committees of the House of Delegates.

He shall seek the advice of officers and trustees.

He shall be an ex-officio member of the Committee on Constitution and Bylaws.

Section 6. *The Vice Speaker.* The vice speaker shall preside for the speaker in the latter's absence or at his request. In case of death, or resignation of the speaker, the vice-speaker shall serve during the unexpired term.

Section 7. *The Secretary-Treasurer.* In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.

The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

CHAPTER VII. THE BOARD OF TRUSTEES

Section 1. *Composition.* The Board of Trustees shall consist of: nineteen trustees elected by the House of Delegates, one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and vice speaker of the House of Delegates, the first vice president and second vice president, and the secretary treasurer. Nine trustees shall be chosen from District 3 and one from each of the other ten districts as defined on the geographical map of the state approved in May, 1946.

Region 1A (comprising the counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside and Winnebago) shall be entitled to one trustee for the two-year trial period approved in Resolution 75A-45 as passed by the House of Delegates on April 5, 1975. During this period, District 3 shall be entitled to an additional trustee.

During this two-year period, the Board of Trustees shall consist of twenty-one trustees.

Section 2. *Duties.* The duties of the Board of Trustees are executive, custodial and judicial.

A. *Executive Duties.* The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority.

The Board of Trustees may establish a not-for-profit corporation of physicians known as the Illinois Foundation for Medical Care.

The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates.

B. *Custodial Duties.* The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

All money received by the Board of Trustees and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursement of money shall be approved by the Board.

The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

All acts of the House of Delegates involving the

expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Board of Trustees before same shall become effective.

Funds may be appropriated to encourage scientific investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

C. *Judicial Duties.* The Board of Trustees shall be the board of censors of the Society. It shall have jurisdiction over all questions of ethics and in the interpretation of the laws of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to component societies, or to this Society.

All questions of an ethical nature before the House of Delegates or the general scientific meetings, shall be referred to the Board of Trustees without discussion. The Board shall hear and decide all questions of procedure affecting the conduct of members on which an appeal is taken from the decision of a component society.

The decision of the Board of Trustees shall be final except that an appeal may be taken by a member charged with misconduct as provided for in the Constitution and Bylaws of the American Medical Association.

Section 3. *Executive Administrator.* The Board of Trustees shall employ an executive administrator (who, when he shall be a physician, may be designated as the executive vice-president) whose duties shall be determined by the Board. He shall be responsible to the chairman of the Board. The Board shall review at each of its meetings the interim activities of the administrator. The Board also shall employ such other people as are needed for the conduct of the affairs of the Society.

Section 4. *Meetings.* The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

Section 5. *Organization.*

A. *Chairman.* The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year. The immediate past president shall temporarily assume the responsibilities of the Chairman of the Board in the latter's absence.

B. *Duties of the Chairman.* The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board.

Section 6. *Quorum.* Ten members of the Board of Trustees from at least seven districts shall constitute a quorum for the transaction of business.

Section 7. *County Societies.* The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 8. *Publication.* The Board of Trustees shall provide and superintend the publication and the distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

Section 9. *Bonding.* The Board of Trustees shall provide at the expense of the Society, adequate bond for those officers and employees of the Society it considers require bonding.

Section 10. *Duties of Trustees.* Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio members of all district committees. He shall report to the Board of Trustees the actions of the component societies on reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. *Vacancies.* If during the interval between two annual conventions, sickness, death, or removal from the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12. *The Benevolence Fund.* Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem proper to be held in a fund to be known as "The Benevolence Fund." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. The assets shall be held in the treasury of this Society in a separate fund. Donations or bequests to the Benevolence Fund automatically become a part of these assets.

Section 13. *Audit and Financial Statement.* The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report also shall specify the character and cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

CHAPTER VIII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Peer Review Committee, and such other committees as required to provide to each component society those services the component society may not be able to provide for itself. District committees shall function only at the

request of a component society within the district.

Complaints initially received by district committees shall be referred immediately to the component society for action.

District committees shall be governed by the procedural rules and regulations governing the counterpart state society committee or by these Bylaws.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

CHAPTER IX. COMMITTEES

Section 1. *Committee Structure.* The committee structure of the Illinois State Medical Society shall be as follows:

A. Councils (standing committees)
B. House of Delegates Committees
C. Board of Trustees Committees
D. Ethical Relations Committee (Chapter XI of these Bylaws)

Section 2. *Councils.*

A. The Medical-Legal Council shall be concerned in the areas of:
 1. Liaison with the Illinois Bar Association
 2. Liaison with courts, particularly where impartial medical testimony is involved.
 3. Implementation of the Impartial Medical Testimony Rule
 4. Legal aspects of medical practice other than in the area of mental health
 5. Licensing and standards of practice.
 6. Quackery
 7. Anatomical gifts and organ transplants

B. The Council on Governmental Affairs shall be concerned in the areas of:
 1. Federal and state legislation—analysis and communication
 2. Legislative liaison—both state and federal
 3. Political education

C. The Council on Education and Manpower shall be concerned in the areas of:
 1. Liaison with medical schools, curricula, etc.
 2. Health manpower and training
 3. Internships, residencies, etc.
 4. Scientific assembly
 5. Student loans
 6. Liaison with Student American Medical Association
 7. Continuing Medical Education

D. The Council on Economics and Peer Review shall be concerned in the areas of:
 1. Relations with governmental purchase of care programs (Medicare, Medicaid, Vocational Rehabilitation, etc.)
 2. Relations with prepayment, insurance and other third party plans.
 3. Fees and fee adjudication
 4. Health care cost and utilization
 5. Peer Review (Part 2 of Chapter XII of these Bylaws)

E. The Council on Environmental and Community Health shall be concerned in the areas of:
 1. Governmental Departments of Health
 2. Public Safety
 3. Occupational Health
 4. Child and School Health
 5. Pollution
 6. Nutrition
 7. Maternal Welfare

F. The Council on Public Relations and Membership Services shall be concerned in the areas of:
 1. Publicity and promotion
 2. News media relations
 3. Exhibits and public service programming
 4. Religion and medicine
 5. New member orientation and membership benefit explanation

G. The Council on Mental Health and Addiction shall be concerned in the areas of:
 1. Facilities and services
 2. Liaison with Department of Mental Health
 3. Legal aspects of commitment, etc.
 4. Narcotics and dangerous drugs
 5. Alcoholism

H. The Council on Social and Medical Services shall be concerned in the areas of:
 1. Health care facilities and services
 2. Emergency and disaster care
 3. Liaison with other health professional and health oriented organizations
 4. Health care of the poor
 5. Problems of aging
 6. Rural health

I. The Council on Affiliate Societies shall be concerned in the areas of:
 1. Liaison between the affiliate society and ISMS.
 2. Scientific resource information and advice to ISMS.
 3. Consultation to other councils, e.g., postgraduate education, health care delivery, publicity, legislation.
 4. Advances of medical science in special fields.

J. Planning and Priorities Committee. This committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties, it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President. The President-Elect shall serve as the chairman of the committee.

Section 3. *Organization of Councils.*

A. Councils and the chairmen thereof shall be appointed by the Board of Trustees.

B. Each Council shall have authority to request the Board of Trustees to appoint subcommittees under the councils for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of each subcommittee and shall be selected by the Board of Trustees. Each subcommittee shall be used only for the specific purpose or pur-

poses assigned to it and shall terminate as soon as its final report has been made or at the direction of the Board. The chairman of a Council may not serve as chairman of any subcommittee of the Council.

C. Members of the Illinois State Medical Society (who are not voting members of the Board of Trustees) may be appointed to serve as chairmen or members of any council or committee. Students nominated by Illinois Chapters of the American Student Medical Association, or other recognized student organizations approved by the Illinois State Medical Society Board of Trustees to serve with Illinois State Medical Society members on appropriate committees, may by action of the Board of Trustees, be accorded membership in this classification for the term of the committee appointment. Such members shall be permitted full privileges of committee membership, including (with the permission of the House of Delegates) the right to speak on the floor of the House, but to have no vote out of committee. Voting members of the Board of Trustees may serve as advisory members to any council or committee.

Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society.

A state committee which reviews the decisions of a similar committee of a component society may not have as a member one who currently serves on the same committee of a component society or district.

D. Each Council shall submit for adoption a budget for the ensuing year which shall include any subcommittees, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.

E. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members without vote of the various Councils, and may attend all committee meetings.

F. Terms of office of members of the councils shall be one year, but may be terminated at any time at the discretion of the Board. No member of a council shall serve more than five consecutive one-year terms.

G. Vacancies on any council or subcommittee thereof may be filled or membership therein may be enlarged or decreased by the Board of Trustees. The areas of concern of councils may also be enlarged or decreased by the Board of Trustees.

H. The chairman of a council or subcommittee thereof. when he considers it expedient and with the consent of two-thirds of the members of the council, may conduct business or hold meetings by mail or by conference call, provided all members of the council are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all members.

I. Reports of subcommittees shall be made by the chairman to the council under which they are operating.

Reports of council activities shall include recommendations on reports and requests from subcommittees, and shall be made to the Board of Trustees by the chairman of the council.

The chairman of any subcommittee may request the Board of Trustees to allow him, or any member of his subcommittee, to appear before the Board and to be heard.

All councils shall submit to the House of Delegates written reports summarizing all actions. Requests for House action or recommendations affecting medical society policy must be submitted to the House in resolution form.

J. *Affiliate Societies*

1. *Qualifications.* Affiliate societies shall be those recognized societies of Illinois
 a) as may be approved by the Board of Trustees
 b) which desire representation on the Council on Affiliate Societies

2. *Representation.* Each affiliate society shall be entitled to one member on the council. This representative shall be a member of ISMS.

Section 4. *House of Delegates Committees.* House of Delegates Committees of the Illinois State Medical Society shall be as follows:

A. Committee on Credentials shall consider all questions regarding the registration and credentials of the delegates. It shall distribute and receive the attendance slips for each session of the House of Delegates and perform any other duties assigned to it.

B. Committee on Rules and Order of Business shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates.

C. Committee on Tellers and Sergeants-at-Arms shall:
1. Serve the speaker of the House of Delegates.
2. Distribute, collect and tally votes when a ballot is taken or a numerical tally is required.
3. Certify those in attendance in closed or executive sessions of the House of Delegates.

D. Committee on Changes in the Constitution and Bylaws shall consider all proposed amendments to the Constitution and Bylaws. The chairman of the Trustees Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee to the House of Delegates.

E. Ad hoc committees may be appointed by the speaker of the House of Delegates as the needs arise and any member of the Illinois State Medical Society may serve upon such committee. The number appointed to such committees shall be at the discretion of the speaker and the term of the committee shall be for such duration as is necessary to complete the task assigned but shall not exceed a duration of one year. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees, keeping it informed of all current activities.

F. Such other reference committees as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive administrator, the reports of committees pertaining to administrative activities, economics activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

Section 5. *Organization of House of Delegates Committees.*

A. Immediately after the organization of the House of Delegates at each annual or special meeting, the speaker shall announce the appointment from among the members of the House, of such committees as may be deemed expedient by the House of Delegates.

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

B. References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.

C. Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

Section 6. *Board of Trustees Committees.* The Board of trustees shall form the following committees within itself:

A. The Executive Committee shall consist of the president, president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the chairman of the Policy Committee, the secretary-treasurer, the trustee-at-large, and the immediate past chairman of the Board, provided he is still a trustee.

The Board of Trustees may delegate to the Executive Committee any authority which it possesses and may authorize it to act in any given situation. In all matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Medical Benevolence Committee and Policy Committee and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

B. The Finance and Medical Benevolence Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

This committee shall also:

1. Examine applications to the Society for assistance under the Medical Benevolence to determine eligibility for assistance;
2. Keep the names of the beneficiaries confidential and known only to the committee;
3. Recommend the allotment for each recipient; and
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

C. The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

D. The Ethical Relations Committee shall be constituted and function as stipulated in Chapter XI, Discipline, Part 2, Illinois State Medical Society procedures.

E. The Committee on Constitution and Bylaws shall consist of five members of the Board appointed by the chairman and it shall:

1. Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws.
2. Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws.
3. Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

F. The Committee on Publications shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal.*

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal.* It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish format, cover, type faces and general layout of the *Journal.*

It shall review, edit and supervise the publication of other materials as directed by the Board of Trustees.

G. The Advisory Committee to the Auxiliary shall consist of the immediate past president as chairman, the president and the chairman of the Board of Trustees.

The committee shall provide advice and assistance to the president of the Woman's Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

H. The Board of Trustees may from time to time appoint such ad hoc committees as it may deem necessary but the duration of such committees shall be temporary and they shall function only for the specific purpose assigned and shall be terminated as soon as final reports have been made or at the direction of the Board.

Section 7. *Powers of the Board of Trustees.* The Board of Trustees shall have power to increase or decrease the number of its committees, to change the area of concern of such committees, to enlarge or decrease membership and to fill vacancies thereon.

Section 8. *Term of Membership.* The term of the members of the Board of Trustees Committees shall be for a duration of one year and they shall be selected by the Board annually immediately after the election of officers.

CHAPTER X. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not had a fair trial, shall have the right of appeal to the Board of Trustees.

Section 6. When a member in good standing in a component society changes his residence to another county in this state, such change of residence shall terminate his membership in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes and it shall accompany his application for membership. The board of censors of the society receiving this application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

Section 7. A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in which his county is situated.

Section 9. The secretary of each component society shall forward its roster of officers and members, and a list of delegates and alternate delegates to the secretary of this society no later than 120 days prior to annual meeting.

Section 10. Any component society which fails to pay its assessment or make the annual report required on or before March fifteenth shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

A member is in good standing unless otherwise disqualified, whose dues are paid on or before the first day of March of the current year. Immediately after the first of March, each delinquent member shall be notified that in consequence of nonpayment of dues, his membership is delinquent. If dues remain unpaid as of June thirtieth of the current year, membership shall be dropped automatically. The member may be reinstated by paying all delinquent dues, provided, in the interim, he has not been guilty of conduct prejudicial to membership; but if two or more years have elapsed since he was a member in good standing, he must in addition, make application as a new member.

Section 11. The Constitution and Bylaws of the Illinois State Medical Society and of the American Medical Association, together with the Principles of Medical Ethics of the American Medical Association, shall be binding upon the members of the component societies.

CHAPTER XI. DISCIPLINE

PART 1. COMPONENT SOCIETY PROCEDURE

Section 1. *Local Ethical Relations Committee.* Each component society may have, either by appointment or election, an Ethical Relations Committee, whose duty it shall be to prosecute formal charges of unethical conduct. In the event that the county society does not have such a committee, the district Ethical Relations Committee shall function in its behalf.

All parties may have legal counsel present to advise and counsel them during the proceedings, but such counsel may not participate in the proceedings, and may be excluded from the hearing by the chairman or by vote of the committee.

The component society Ethical Relations Committee may establish reasonable rules of procedure, and they shall not be bound by the technical rules of evidence as the same pertain in courts of law. In all proceedings before such Ethical Relations Committees, the complainant, the accused and all witnesses before the committee shall be placed under oath.

The Committee shall evaluate acts by the standards established by the House of Delegates of the American Medical Association (specifically known as the Principles of Medical Ethics of the American Medical Association), and by such additional standards as shall be incorporated in the Constitution and Bylaws of the Illinois State Medical Society and/or the county medical society.

Section 2. *Offenses.* Any member of a component society shall be subject to censure, suspension or expulsion by such component society when

A. He has been adjudged guilty by proper civil authorities of a criminal offense involving moral turpitude, or

B. He has been adjudged guilty by his component society in accordance with the procedural requirement of these bylaws:

 1. of a gross misconduct as a physician, or
 2. of a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association.

Section 3. *Formal Written Charges Presented to the Illinois State Medical Society.* Formal, written charges received by the Illinois State Medical Society shall be referred directly to the secretary of the component society of which the charged individual is a member or to the district Ethical Relations Committee in the event that the component society does not have an Ethical Relations Committee.

Section 4. *Principles of Justice.* The following principles of justice shall guide the Ethical Relations Committee in all disciplinary procedures.

A. A charged individual is presumed to be innocent until he has been proven guilty.

B. No proceeding shall be initiated under this Part I until formal written charges have been filed with the secretary of the component society or the district Ethical Relations Committee, as the case may be. Thereafter, said formal written charges must be presented under oath or affirmation by the complaining party before the Ethical Relations Committee of the component society or the district Ethical Relations Committee, as the case may be.

C. A hearing shall be held by the committee within 30 days after the formal written charges have been filed, unless continued by the chairman of the committee upon good cause shown.

D. In the event that a component society's Ethical Relations Committee does not make a reasonable effort to hold the hearing within the time period, including reasonably granted continuances, either the complaining party or the physician, against whom formal written charges have been brought, may appeal for relief and hearing to the district Ethical Relations Committee, which will determine the reasonableness of the effort.

E. The individual against whom formal charges have been filed shall be sent a copy of said charges by certified mail at least 10 days before the date set for the hearing, together with a statement of the rights of the charged individual as follows:

 1. to be represented by any member of the society as counsel and that he may have legal counsel present;
 2. to cross-examine witnesses;
 3. to offer in evidence any pertinent records or documents;
 4. to object to any testimony or exhibits offered in evidence;
 5. to address the hearing body in his own behalf;
 6. to be tried only on the specific charges filed;
 7. to have stricken from the record any improper testimony or exhibits;
 8. to appeal to the Board of Trustees of the Illinois State Medical Society.

Section 5. *Records.* A comprehensive stenographic record of the proceedings, together with all exhibits, must be kept for reference, and shall be available until final adjudication has been made.

In the event of an appeal being taken from the verdict of the local or district Ethical Relations Committee, the stenographic record shall be forwarded by certified mail to the Board of Trustees of the ISMS at least ten days prior to the date the appeal is to be heard.

If the component society fails to provide the record on appeal, the Ethical Relations Committee of Illinois State Medical Society shall find the charged individual not guilty.

Section 6. *Verdict.* The committee, sitting as a hearing body, shall recommend the charged individual be found either guilty or not guilty. If the verdict is guilty, the hearing body shall recommend censure, suspension or expulsion.

The findings of the hearing body must be presented to the component county society for approval or rejection. The charged individual must be notified by certified mail at least ten days before the date set for the meeting at which this action will be taken. If the findings of the component society are against the charged individual, the secretary of the component society shall acquaint the charged individual by certified mail, with his right of appeal within thirty days to the Board of Trustees of the Illinois State Medical Society.

PART 2. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

Section 1. *Illinois State Medical Society Ethical Relations Committee.* The Board of Trustees shall appoint from its members, an Ethical Relations Committee to review decisions of the component society involving the inter-

pretation of the Principles of Medical Ethics, violations of the Constitution and Bylaws of the Illinois State Medical Society or its component societies, and charges of misconduct of members of the Society.

Section 2. *Appeals from Component Society Verdicts.* Appeals received by the Illinois State Medical Society Board of Trustees shall be referred to the Ethical Relations Committee of the Board for review. (Appeals must be accompanied by a comprehensive stenographic record of the proceedings taken before the component county society together with all exhibits submitted in evidence. If the component county society fails to provide the record on appeal, the Ethical Relations Committee of the Illinois State Medical Society shall find the accused "not guilty"). The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for the hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees.

Section 3. *Verdict.* The Ethical Relations Committee of the Board of Trustees shall hear any new and pertinent evidence any interested party desires to present, and at the conclusion of the trial the decision of the component society shall be affirmed, overruled or sent back to the component society for reconsideration.

Section 4. *Notification and right of appeal.* The secretary of the Society shall notify the defendant and the secretary of the component society wherein the defendant holds membership, of the action of the Board. In the event of a decision against the accused he shall have the right to appeal the decision to the Judicial Council of the American Medical Association and the secretary of the State Society shall so notify the accused of this right.

CHAPTER XII. PEER REVIEW

PART 1. COMPONENT SOCIETY PROCEDURE

Section 1. *Local Peer Review Committee.* Each component Society shall have, either by appointment or election, a Peer Review Committee whose duties it shall be to review all proper complaints and inquiries brought before it by physicians, patients, institutions, insurance carriers, or government agencies.

The district peer review committee shall function and operate on behalf of any county society which does not establish such a committee.

Section 2. The committee shall consist of a chairman and such members representing the various specialties, including family practice, as each individual county society shall determine. Such committee should have access to counsel from each of the various medical specialties. The component county society may establish reasonable rules of procedure but shall not be bound by the technical rules of evidence as the same pertains in courts of law. All proper complaints shall be reduced to writing and shall be signed by the individual making the complaint.

Section 3. Original complaints received by the Illinois State Medical Society shall be referred to the proper county society or to the district committee.

Section 4. The Peer Review Committee shall include the functions of the grievance committee, the prepayment plans and organizations committee, the mediation committee and any other committee having to do with investigations and review but shall not replace or supersede the ethical relations committee.

Section 5. The Peer Review Committee shall initiate consideration of all complaints and matters filed with it within 60 days from the date of filing and shall render an opinion within 30 days after the conclusion of the hearing. In the event the committee does not follow this procedure any party may appeal for relief to the proper district committee whose procedure shall be the same as is set forth herein for county societies.

Section 6. The Peer Review Committee shall have no disciplinary powers but instead, shall report its findings in writing to all parties involved. In the event the investigation and study of the committee results in a determination that there has been a violation of law or unethical conduct on the part of any physician, or a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association, the matter shall be referred in writing to the component society.

Section 7. In its study and deliberations the Peer Review Committee shall evaluate acts by the standards established by the House of Delegates of the American Medical Association (specifically known as the Principles of Medical Ethics of the American Medical Association), and by such additional standards as shall be incorporated in the Constitution and Bylaws of the Illinois State Medical Society and/or the county medical society.

Section 8. Any party to the proceedings considering himself aggrieved by the findings and recommendations of the committee shall have the right to appeal through the component society to the Illinois State Medical Society.

Section 9. In the event of an appeal to the Illinois State Medical Society, the county society shall send to the Illinois State Medical Society a copy of the complaint, the exhibits and the opinions of the county or district committee. Any appeal hereunder shall be filed with the Illinois State Medical Society wihin 30 days after the final opinion of the county or district committee has been rendered.

PART 2. ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

Section 1. All appeals received by the Illinois State Medical Society shall be referred to the Council on Economics and Peer Review, which shall review opinions of the county or district peer review committee. The council shall have the power to counsel with and obtain information from medical specialists when appropriate. The Council shall have the power to review both the procedural and substantive aspects of any appeal before it.

Section 2. The council upon receiving notice of an appeal shall set the matter for hearing within 30 days after the appeal has been filed and at such hearing shall review the record sent to it from the county society or district society, receive additional pertinent evidence any interested party desires to offer and render its conclusions and findings in writing, copies of which shall be mailed to all interested parties. The Peer Review Committee shall have no disciplinary powers but instead, shall report its findings to all parties involved. The conclusions and findings shall be advisory only.

Section 3. The Council on Economics and Peer Review of the Illinois State Medical Society shall include the functions of the grievance committee, the prepayment plans and organizations committee, the mediation committee and any other committee having to do with investigations and review but shall not replace or supersede the ethical relations committee.

Section 4. In the event the investigation and study of the Council results in a determination that there has been a violation of law or unethical conduct on the part of any physician, or a violation of the Constitution or Bylaws of his component society, or of the Illinois State Medical Society, or of the Principles of Medical Ethics promulgated from time to time by the American Medical Association, the matter shall be referred in writing back to the component society.

CHAPTER XIII. MISCELLANEOUS

The fiscal year of this Society shall be from January 1 to December 31 inclusive.

CHAPTER XIV. AMENDMENTS

The House of Delegates may amend any article of these Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be acted upon before the day following that on which it was introduced.

CHAPTER XV. PARLIAMENTARY PROCEDURES

For those matters not covered by the Constitution and Bylaws of the Illinois State Medical Society, Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for conduct of meetings of the House of Delegates. Board of Trustees and all councils and committees.

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Policy Manual of the Illinois State Medical Society

"Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience."

"Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy."

This manual shall be a guide for officers, trustees, committee chairmen and headquarters staff to the stand taken by the House of Delegates of the Illinois State Medical Society on all issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its next meeting for action. The House may:

(1) approve, amend, or reject—
(2) refer the statement to the Board for reconsideration and subsequent report—
(3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House must be presented in resolution form. A member of the Illinois State Medical Society may propose policy by requesting any delegate to submit an appropriate resolution. The Policy Committee will develop policy statements from actions of the House of Delegates and, after approval by the Board of Trustees, the statements will be published in this Policy Manual.

Temporary policy between meetings of the House is determined by the Board. Committees may request Board consideration at any time.

The Illinois State Medical Society shall support policy statements approved by the House of Delegates of the American Medical Association.

National policy is the prerogative of the national association. Until specific contrary action emanates from the AMA House of Delegates, the Board of Trustees and the officers of the ISMS shall consider all such policy as binding.

Policy action at the state level does not rescind official AMA rulings in Illinois.

The same "chain of command" should exist between the county medical society and the ISMS House of Delegates. Policy established at the State Society level must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic process.

PROFESSIONAL POLICIES

Abortion

The decision to perform an abortion is a medical matter to be determined by agreement between the patient and the physician. Performance of abortions should be carried out in accordance with current guidelines as promulgated by the House of Delegates. If not in conflict with state and federal law, an abortion so performed shall not be considered unethical. No physician shall be required to perform or participate in an abortion.

Acupuncture

Acupuncture is a surgical procedure and its practice should be limited to physicians licensed to practice medicine in all of its branches and to dentists.

Alcoholism

Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression, and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational and/or social adjustments as a direct consequence of persistent and excessive use of alcohol.

Insurance companies are encouraged to include appropriate coverage for alcoholism in health insurance policies similar to coverage for any other illness and general hospitals, both public and private, are encouraged to accept alcoholic patients (both in-patient and out-patient) for detoxification and rehabilitation.

Alcoholism Education

The Illinois State Medical Society supports the concept that medical schools and hospital training programs should expand instruction of students in the treatment of acute and chronic alcoholism, as well as its cause and prevention; that mental health clinics should enlarge their services to include treatment and counseling of alcoholics and their families and, where appropriate, collaborate with Alcoholics Anonymous as well as half-way houses; that education programs aimed at alcohol abusers who are drivers should be encouraged and legal restrictions established to prevent them from holding drivers' licenses; that education of the public (at all age levels) regarding the nature of alcohol and its physiologic and psychologic effects should be encouraged.

Ambulance Services

All ambulance services should meet minimum standards as developed from time to time by the Illinois State Medical Society and the State of Illinois.

Athletic Programs

Children of school age, through the 9th grade, should not participate in body contact sports.

Elementary school children develop better physically if activities are informal and not highly competitive.

Medical supervision of all athletic programs is essential.

Audits & Surveys (Hospital, nursing homes, etc.)

Audits and surveys which impinge on personal privacy, patient care and local hospital trustee and medical decisions as to management should not be condoned.

Birth Control

The preventive medicine approach to the problem of unwanted pregnancies should be encouraged through family life education in the schools, wider dissemination of family planning information, including birth control information and devices, and encouragement of research in population control methods.

Blood Procurement

Inasmuch as blood procurement affects the entire community, any blood procurement program should be carried out only with the approval of the local county medical society involved.

Communicable Diseases

Physicians, especially those engaged in public health work, should enlighten the public concerning all regulations and measures for the prevention and control of communicable diseases. When an epidemic prevails, a physician shall continue his labors without regard to his own health.

Community Health Week

The medical profession shall provide the scientific leadership to focus attention on the health needs of the community and to encourage and assist in developing Community Health Week activities during the winter or spring of the year.

Comprehensive Health Planning

Upgrading of local health facilities should be implemented through Comprehensive Health Planning on a home rule basis rather than through metropolitan oriented advisory services. Where a county medical society is unable to enter into meaningful participation in areawide health services planning, this function may be assumed by an appropriate ISMS District Committee or, where the appropriate District Committee is unable to act, by the Illinois State Medical Society.

Confidentiality

Communications received in confidence by physicians from patients are privileged: the privilege is that of the patient and the physician is the guardian of the privilege and must not betray it. Current day social values dictate that privileges must be continued in accomplishment of the treatment of human illness. Section 9 of the Principles of Medical Ethics states that "A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or the community." The Illinois State Medical Society re-affirms its belief in this principle and supports activities to guarantee continuation of privacy, while recognizing the need for collection of statistical data and enforcement activities in the public good.

The Illinois State Medical Society will take an active role in uncovering any violation of the doctor-patient confidential relationship by officials and personnel of review organizations and will take whatever steps are necessary to eliminate the breach of confidence.

Conflict of Interest

When a case of conflict of interest arises and is self-evident, by the attitude shown by the individual concerned, it should be referred to the Executive Committee of the Board of Trustees of the ISMS for consideration.

Continuing Education

Continuing education shall be one of the basic purposes of the Illinois State Medical Society for scientific advance-

ment, humanization of medicine, improvement of medical public relations, and development of cooperation and rapport with the public. The Society should continue to support the multi-faceted approach to continuing medical education as now endorsed by the Illinois Council on Continuing Medical Education.

All members should be encouraged to participate in the AMA Physician Recognition Award, as presently constituted, or its equivalent.

In the certification of educational quality of continuing medical education programs, the Illinois State Medical Society should have a primary role. Physicians should be encouraged to participate in self-assessment test programs prior to registering for such hospital courses and other learning activities.

Cultists, Association with

The Judicial Council of the American Medical Association has ruled that it is unethical to associate VOLUNTARILY with an individual who practices as a member of a "cult."

Disaster Control

Any disaster creates an obvious need for trained personnel to aid the sick and injured. Local medical societies should cooperate to provide medical self-help programs. County societies should provide training for their membership in the treatment of mass casualties, radiological casualties and in the organization, operation and maintenance of emergency hospitals.

Discrimination—(see "Freedom of Choice")

Drugs, Prescriptions

Substitution of prescribed drugs by pharmacists is opposed, except in cases of extreme emergency, unless there be full explanation and agreement by both the patient and the doctor.

The package insert labeling pharmaceutical preparations is a guide for the clinical application of the product and should not be used as an absolute standard limiting the practice of medicine.

Ethics

Cases involving ethics shall reach the state society level only by means of an appeal. As outlined in the Bylaws, the state society committee shall serve only as an appellate body to review such cases.

Examinations

All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

This general statement does not apply to the industrial or occupational health physican in his in-patient activities.

Experimental Medical Procedures

In order to conform to the ethics of the American Medical Association, three requirements must be satisfied in connection with the use of experimental drugs or procedures:

1. The voluntary consent of the person on whom the experiment is to be performed should be obtained.
2. The danger of each experiment must be previously investigated by animal experimentation.
3. The experiment must be performed under proper medical protection and management.

Fee Schedules

No member or committee shall be permitted to approve a fee schedule for the Illinois State Medical Society until it has been submitted to and approved by the House of Delegates or the Board of Trustees. Fees should be commensurate with services rendered.

Freedom of Choice

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the patient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.

Foundations for Medical Care

The Illinois Foundation for Medical Care is a not-for-profit corporation established to provide physicians with leadership roles in modifying health care delivery in their communities, thus assuring quality care at reasonable cost. Establishment of autonomous county and/or multi-county foundations under the sponsorship of local medical societies is encouraged and, together, local and state foundations shall provide a mechanism through which foundation-sponsored programs can be developed and administered throughout the state.

Governmental Health Insurance Programs

Governmental health insurance benefits for mental illness should be comparable to benefits for any other medical condition.

Governmental health insurance programs providing reimbursement for medical services under the direction of practitioners other than doctors of medicine or osteopathic medicine should establish a separate category for such reimbursement, with separate payment, and be optional to the insured.

Health Care—Ancillary Services

All segments of our population are entitled to and shall receive the best health care available. The physicians in Illinois are encouraged to cooperate in the implementation of any national program meeting with the general policy statements of the Society. (This shall be interpreted to include health aspects in nursing home care, use of recreational facilities, environmental health, public health, employment problems, problems of migrant workers, etc., and any other area which involves the health of the people of this state.)

Health Care Costs

The public should be educated concerning the difference between "health care costs" and "medical care costs."

Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

Health Careers

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in paramedical fields shall be provided with all pertinent information.

Health Screening by Paramedical Personnel

Health evaluation, to be adequate, must include a physical examination only by or under the direct supervision of a physician licensed to practice medicine in all of its branches with physician interpretation of the appropriateness and reliability of various screening procedures used.

Hospitals

Physicians should sponsor and assist in the development of all medical staff committees within the hospital.

The local medical profession should cooperate to achieve the accreditation of all eligible hospitals, and should encourage the stabilization or reduction of hospital costs in all areas where they have authority.

The Illinois State Medical Society encourages the development of local peer review plans for appropriate review of utilization of hospital emergency rooms.

Hospital-Medical Staff-Management Relationship

Any proposal or arrangement between institutional management and medical staffs should not conflict with the Principles of Medical Ethics or abridge the property right endowed upon the individual physicians by the Illinois Department of Registration and Education. The practice of medicine is the physician's legal prerogative and responsibility. To insure the quality of medical care, each hospital has the obligation to cooperate with and assist its medical staff in implementing procedures by which the quality of medical care in that hospital may be maintained by and through its medical staff.

Hospital Records and Their Availability

Hospital records are privileged information and the property of the patient, kept in trust by the hospital. They are not to be released except on a court order.

Upon receipt of a request signed by the patient, an abstract or a summary shall be provided when needed, to insurance companies, governmental agencies, consulting physicians, etc.

Hospital Staff Assessments

The medical staff of a hospital does not have the privilege or the right to make compulsory assessments of members of the medical staff for building funds, or to demand an audit of staff members' personal financial records as a requisite for staff appointments.

Immunization Program

Illinois residents should be provided all types of immunization. Physicians are requested to provide this protection especially to all children, or to encourage the local public health agency to perform this function.

Every school should have a school health committee with at least one physician as a member. County advisory school health councils should assist in coordination.

Impartial Medical Testimony

The ends of justice are served when impartial medical witnesses are available to give testimony. The ISMS supports this concept and offers its assistance in the provision of impartial medical testimony.

Indigent, The Care of the

Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.

Insurance Plans for Patients

ISMS endorses the principle of voluntary health insurance. Fixed fee schedules should be recognized as indemnification to the patient and not necessarily payment in full.

Inasmuch as the fee coverage by insurance plans may not cover the full fee of the physician, the physician is encouraged to develop a prior agreement with the patient, such as the "Statement of Understanding." This will outline to the patient his individual responsibility for the physician's fee.

Laboratories

All laboratories providing medical data should be under the direct supervision of a physician.

Medical Care, Provision of

Medical care shall be provided regardless of the ability of the patient to pay. Physicians shall not refuse to render needed emergency care to any patient.

Medical Diagnosis and Treatment

Third parties, including government personnel, insurance carriers, review organizations and hospital personnel should be informed and educated that the Illinois State Medical Society endorses the concept that prognosis and length of treatment must always be individualized to the patient, rather than to the diagnosis.

Medical Education

The Illinois State Medical Society supports development of innovative curricular and co-curricular programs in medical education maintaining a firm foundation in the basic sciences.

Medical Examiners

ISMS favors a medical examiner system throughout the state in preference to a coronor system, wherever practical.

Medical Psychotherapy

Medical Psychotherapy is a medical procedure for the treatment of mental and physical ailments or illness. It involves verbal and non-verbal communications with the patient, and always includes continuing medical diagnostic evaluation and drug management as indicated. Medical psychotherapy may be performed only by a physician licensed to practice medicine in all of its branches, who has had training in psychiatric medicine.

Mental Health

The Illinois State Medical Society strongly opposes the double standard of care in state hospitals and favors elimination of permit physicians (unlicensed physicians practicing in state institutions). Every effort should be made to extend educational opportunities to these permit physicians to enable them to achieve full licensure.

Each constituent county society should cooperate fully with and support local units of the Department of Mental Health in their patient care efforts, specifically seeking to encourage:

1. Local general hospitals to accept mental health patients who can be helped by short-term treatment, leaving to state institutions the responsibility for such chronic and long-term cases which local hospitals cannot presently handle.
2. Local general hospitals and practitioners to retain in their own care those geriatric patients who have ailments of primarily a physical nature.
3. Local physicians, local hospitals, and local skilled nursing facilities to provide primary and secondary care for psychiatric problems to the extent possible; given facilities and physician-time available.
4. Arrangements for emergency mental health care, i.e., crisis intervention, to be available areawide.

All physician or other health service provided to the Department of Mental Health, other than that by full-time employees, should be on the same fee-for-service basis as any other medical service which is paid by the patient or third party insurer.

A physician licensed to practice medicine in all its branches should be required to certify the discharge of any patient from a psychiatric institution.

Minors, Medical Treatment of

Where parental consent is not legally required for medical treatment of minors, the physician's judgment shall prevail as to whether or not the parents should be notified of such treatment.

Multiphasic Screening

Automated multiphasic health testing and screening laboratories are recognized as an extension of services available to the physician for the health needs of individual patients. A position statement on multiphasic health testing, developed by the ISMS Council on Environmental and Community Health, and the American Medical Association Guidelines for establishing and operating such programs are attached as an appendix to the Policy Manual.

Nurses—Shortage

A severe shortage of graduate nurses continues to imperil the provision of quality patient care. The ISMS supports all forms of qualified nursing education and urges that all such schools be encouraged to remain in operation.

Nursing Homes

Every patient receiving long-term nursing care should have an attending physician who acknowledges his continuing responsibility in writing. Responsible parties, preferably the patient or immediate family, should be urged to select a physician.

Nutrition

Prophylactic use of iron fortified foods is approved in accordance with a 7-point statement developed by the Nutrition Committee and the Council on Environmental and Community Health in 1971.

Occupational Health

Occupational health is an essential ingredient of employee welfare. The adoption and development of health programs in industry should be encouraged.

Occupational health will be advanced through the utilization of industrial physicians.

Osteopaths, Association with

Voluntary professional associations with a Doctor of Osteopathy are not deemed unethical if the Doctor of Osteopathy bases his practice on the same scientific principles as those adhered to by members of the American Medical Association and if he is licensed to practice medicine and surgery in all of its branches in Illinois.

Physician-Patient Relationship

All committees dealing with the review of physician-patient relationship in hospitals and nursing homes are urged not to release findings to any third parties except by subpoena or court order. Any reports issued by the committees involved should be submitted to the chief of staff for his disposition.

Prepayment Plans and Organizations

It is not within the province of ISMS to act in other than an advisory capacity when working with a "third party plan," and its best efforts should be directed toward supplying guidance, education and communications between the membership and the prepayment plans and organizations involved.

The principle of free enterprise as exemplified by private insurance companies and the "Blue" plans is to be endorsed.

Such plans should recognize that free standing medical and surgical facilities are acceptable methods of delivering high quality health care. Reimbursement for expenses incurred as an outpatient in such facilities should be included in the benefits of these plans.

Psychosurgery

Psychosurgery refers to those surgical operations which irreversably destroy brain tissue for the primary purpose

of treating mental disorders. Psychosurgery does not include procedures undertaken to treat definable disease states such as tumors, epilepsies, aneurysms and chronic pain syndromes, nor does it include electrical stimulation of the brain, such as electroconvulsive therapy. Psychosurgery should not be performed without adequate documentation of indications, adequate consultation and reasoned consent.

Public Aid

The "chain of command and procedure" in handling problems arising in the field of public aid shall be from the county to the state advisory committee; then the state advisory committee shall assume the responsibility of making the medical program work and cooperating with the Illinois Department of Public Aid to maintain the best type medical care for the recipients of state aid.

The fees paid by the state/federal programs to physicians shall be based upon the usual and customary fee concept.

An extensive program of education should be conducted for the recipients of public aid. This should include the intelligent handling of all monies provided.

Rehabilitation of all recipients should be of paramount concern.

Public Health Departments

Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts, including contributions by voluntary health associations, medical societies and other health-oriented groups.

Full-time modern local health departments adequately financed and staffed at the county or multiple county level are highly desirable and if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support.

Local public health service jurisdictions should be consolidated into sufficiently large geographic and population districts to achieve program efficiency.

Public Safety

Motor vehicle operators should be licensed on the basis of the applicant's physical and mental capacity to operate such a vehicle safely.

Rehabilitation

All physical rehabilitation activities should be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services

Insurance carriers should be encouraged to include rehabilitation services in their contracts.

Relative Value

The Relative Value Study is not a fee schedule and is to be used for information only. All fee payments should be based on the usual, customary and reasonable concept.

No co-efficient shall be established at the state level. The data contained in the study may be used by the ISMS, its committees or by any county medical society.

The study should be revised at appropriate intervals upon recommendation of the Relative Value Committee with approval of the Board of Trustees.

Upon request, copies may be furnished third party purveyors of health care services.

Smoking

The Illinois State Medical Society is opposed to the sale of tobacco and tobacco products in hospitals and will encourage medical staff action to make hospitals tobacco smoke-free.

Specialty Society Representation on ISMS Councils

For the improvement of communication and the discussion of problems of mutual interest and concern, closer liaison between specialty societies of medicine and the councils of the Board of Trustees is desirable. Representatives to serve in this capacity may be nominated by the specialty society, approved by the Board of Trustees of ISMS, and designated as consultants to the council without vote, in compliance with the Bylaws.

Veterans Administration

It is our belief that a Veterans Administration hospital should admit only those patients with service-connected disabilities, except in those instances where the veteran is financially unable to pay for his medical care and hospital services, as shown by a means test.

ADMINISTRATIVE POLICIES

AMA-ERF

The Illinois State Medical Society's dues billing form shall include the names of all medical schools in Illinois so that every member may designate which school is to receive his AMA-ERF contribution.

Assessments

Compulsory assessments of members of hospital staffs for any purpose are unethical and improper.

Autonomy of County Medical Services

In all areas, the county medical society shall be autonomous, except that no ruling by any county medical society shall conflict with the Principles of Medical Ethics of the American Medical Association or with the Constitution and Bylaws of the Illinois State Medical Society.

Birth Certificates

Birth certificates should contain only such items as are pertinent to their function. Information recorded on birth certificates should not be provided to organizations or individuals for other than approved purposes.

Budgets—(see "Financial Policies")

Committee Appointments

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Elective committees should serve for uniform terms of office—preferably three years. These terms of office should be held on a staggered basis to provide continuity in the committee structure. Individual tenure on any committee should be limited to a maximum of nine years of continuous membership—whether elected or appointed.

Physicians appointed to an Illinois State Medical Society committee must be members in good standing of this Society.

Constitution and Bylaws

Final copy of any changes made by the House of Delegates in the Constitution and/or the Bylaws shall be prepared for publication by the Committee on Constitution and Bylaws, in consultation with legal counsel, making sure that the published changes reflect the thinking expressed by the action of the House.

Co-operation with the American Medical Association

Actions of the AMA House of Delegates are binding upon its membership at all levels, county, state and national.

(Since all members of the Illinois State Medical Society are also members of the American Medical Association, this is universally true in Illinois. The right to disagree, the right to protest, the right to become "the loyal opposition" is not questioned. However, until such time as the AMA House has reversed its decision, it is mandatory that the membership abide by the will of the majority.)

Dues, Recommendation of the Board to the House

The chairman of the Board of Trustees shall place the question of dues for the coming year on the agenda for consideration by the Board of Trustees in time for the Board to present its recommendations to the House of Delegates each year.

Immediately following this meeting, written notice of the recommendation regarding dues for the next fiscal year, shall be mailed to all delegates and alternate delegates from the component societies, and also to all presidents and secretaries of county medical societies. This recommendation shall also be published in the *Illinois Medical Journal* as a part of the annual report of the Chairman of the Board.

Education, Primary and Secondary

Primary and secondary education is a community problem. In order to retain jurisdiction of these grade schools, finances should be raised by taxation at the local level.

Facility Medical Boards (Physicians)

In all legislation which establishes boards for the administration of medical facilities operated by governmental units, at least one-third of the board should be physicians licensed to practice medicine in all its branches.

Federal Funds

When a federal government assistance program is essential it should be conducted under the administration and control of local government. The Society does not favor any federal assistance program which removes administrative control from the state or local level.

Financial Policies

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(4) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(5) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(6) In addition to fixed reserves, the development of a contingency reserve is desirable.

(7) All financial records shall be available at headquarters office, and may be examined by any member of the Society. A semi-annual summary of the financial statements of the Society shall be mailed to any county society secretary or delegate if requested. A projected budget for the next fiscal year shall be mailed to the members of the House of Delegates at least 30 days prior to the annual convention. These reports shall be in the format customarily used in ordinary corporate practice.

House of Delegates, Special Meetings of

When a special meeting of the House of Delegates is scheduled which may involve an increase in dues or a special assessment, the call for that meeting shall contain specific notification of that possibility.

Individual Rights

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with this Society's basic philosophy.

Journal Publications

The Publications (Journal) Committee, with the approval of the Board of Trustees, has authority over the publication policy and the screening of all advertisers and advertising copy appearing in the *Illinois Medical Journal*.

Lay Employees' Functions

Policy is established by the House of Delegates.

Staff shall cooperate with officers and committee chairmen in setting up activities and in carrying out all necessary routine.

Staff also shall keep new officers and committee chairmen aware of policy statements, and assist them in the preparation of reports to the House of Delegates to:

change existing policy

establish new policy

request House approval of committee projects and/or procedure involving policy.

Committees shall be informed of their right to set up operating rules and regulations.

Legal Counsel

The legal counsel of the Illinois State Medical Society shall concern himself with official inquiries from officers, trustees, committee chairmen and county medical societies. Such inquiries shall be channeled through the Executive Administrator.

Legislation

All matters pertaining to state or federal legislation shall be referred to the Governmental Affairs Council for consideration and recommendation prior to Board of Trustees and/or House of Delegates action.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Council on Governmental Affairs of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Governmental Affairs which shall work in close cooperation with any other Society committee involved. The instigating committee should determine the content of the law and the Governmental Affairs Council primarily should consider relationship of the proposed legislation to the total legislative program.

Any Council or Committee recommending legislation to the attention of the Governmental Affairs Council must provide expert witnesses when called upon to testify before Senate and House Committees in support of, or in opposition to, the legislation recommended by the Council or Committee.

Legislative Intrusion into Medical Judgment

The Illinois State Medical Society opposes any and all legislative efforts to interfere with physicians' judgment as to which procedures are appropriate and in the best interest of his or her patients and ISMS will work aggressively to oppose any legislation abridging the physician's prerogatives in this regard.

Mailing List

The use of the mailing list of ISMS members must be approved by special action of the Board of Trustees.

Medical Representation in Government Planning

In health programs financed by government funding in an Illinois community, there shall be representation at the highest policy level by an official representative of the State Society and the appropriate county medical society involved. Remuneration for services in above programs shall follow the policies of the Illinois State Medical Society.

Only those programs which have involved physicians at the local level in the planning and development stages shall be approved by ISMS.

Unless physicians appointed to the boards and committees of other organizations, such as local Comprehensive Health Planning "b" agencies, are nominated by their local county medical society, such physicians shall not be considered "representative" of the medical community.

Membership in Paramedical and Service Organizations

Membership in Chambers of Commerce (city, state and national) is to be encouraged. This policy extends to the individual physician as well as to the component societies.

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.

Membership of Osteopathic Physicians in ISMS

Osteopathic physicians who meet all qualifications for membership, base their practice on the same scientific principles as those adhered to by members of the AMA, and are licensed to practice medicine in all its branches in Illinois, may be accepted as active members by the county medical societies throughout the state, and be accorded all privileges of full membership at the county and state levels and be so reported to the American Medical Association for acceptance at that level.

Placement Service

Before the Physicians' Placement Service recommends that a town in Illinois be listed as needing a physician, it shall be established that the need actually exists; that the community can support a physician; that certain physicial assets (office—home—schools, etc.) are available for the physician and his family.

The qualifications of the physician also shall be ascertained prior to furnishing him with the list of available areas in Illinois needing a physician.

Policy Statements

Policy statements shall be defined as guide lines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience.

Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy.

Polls, Opinion

The vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership. Since delegates are the duly elected representatives of their county medical societies and their voting reflects the thinking of their constituents, a majority opinion has been expressed, and a membership poll becomes unnecessary except under very exceptional conditions.

Press

All county medical societies should be encouraged to cooperate with the local press. The public should be provided with prompt and accurate information in all health fields; the source of this information should be the medical profession.

County medical societies should provide information at the local level; the State Society is responsible for press releases involving State Society officers or any official statements of the Society appearing in the press.

A code of ethics applicable to medicine and the fourth estate should be developed. (That used in the Decatur area has been given national recognition by the AMA.)

Professional Liability

The Illinois State Medical Society endorses the concept of effective peer review in all matters related to the professional liability of physicians including the right of individual physicians to appear before appropriate peer review committees responsible for his liability insurance coverage.

Publication of Research Data

In releasing research material for publication in the *Illinois Medical Journal,* or any other media, extreme care should be exercised. The welfare and privacy of the patient, the professional reputation of the physician should be of primary concern.

If any question arises, consultation with the Board of Trustees is suggested. All such inquiries should be addressed to its chairman.

Public Affairs

No officer or member of the Board of Trustees should be permitted (during his term of office) to allow his name as an officer or a member of the Board to be used in lists endorsing candidates for public office. Naturally his right to this privilege as a private individual is not affected.

Rebates

In conformity with the AMA Principles of Ethics, rebates of any nature to any member, county or regional medical society, are unethical. This statement on rebates was developed as a result of a letter regarding collection services. It read in part:

"It is our policy to remit to a participating association the sum of 10 per cent of the gross book sales to its members in addition to 10 per cent of the gross commissions received from collections. A report and accompanying payment is submitted monthly from our office."

Reference Committee Appointments

Whenever possible at least two members shall be retained on all reference committees for the following year in order to effect continuity of experience.

Reference Service

Physician reference service shall be the responsibility of the county medical society. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved.

Stationery, Use of Official

No officer, trustee, committee chairman or staff director is to use the official stationery of the Illinois State Medical Society for personal statements of any nature. This shall pertain especially to the endorsement of any candidate for public office.

Surveys

The Illinois State Medical Society endorses the principle of mass surveys and encourages the use of this method whenever it meets with the approval of the local county medical society.

Any new state program involving more than one county society should be submitted to the Board of Trustees for initial approval.

Uniform Health Insurance Claim Form

The Illinois State Medical Society supports the use of the Health Insurance Claim Form developed by the AMA Council on Medical Service by all insurance carriers and physicians.

ISMS Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.

Policy Manual
APPENDIX

Multiphasic Health Testing
Council on Environmental and Community Health Statement

During the recent past there has been an upwelling of various automated or multiphasic health testing or screening programs. The use of the results of such testing has at times led to a false sense of security on the part of patients, whereas other programs are being foisted on the public with the view to making money with very little concern for an individual's well being. Other programs are offered as having direct, immediate and practical medical value, without review by a physician. These many concerns prompt the necessity of a position statement on the use and application of such programs.

There is a place for computer and automated multiphasic testing and screening programs as an extension of the services available to the physician as he considers each individual case. It is entirely possible that such a mechanism will enable a physician to expand his scope of operation.

Forms of automated multiphasic health testing have been used by public health agencies and centers for developmental research in epidemiology. In these programs, asymptomic control patients have been tested. Testings have been done to establish medical priorities or case findings in communities. Other testing has been done to separate those who probably have certain characteristics from those who do not.

Occupational or industrial health programs have used testing programs for the betterment of employees' health and working conditions. Programs such as these, whether a pre-employment examination or a study to control health hazards, are not necessarily related to medical care as such. The physician in charge may or may not at the same time be the attending physician of the employee.

As far as automated multiphasic health testing programs for individuals are concerned, these programs obtain health-related data and act as data collecting sources, following a routine using technicians or mechanical and electronic devices to determine facts. In several hours a variety of tests and measurements can be made which may provide a profile of an individual's physical status. Such a profile can be of value to a physician. The testing is not diagnosis or interpretation.

Some individually oriented automated multiphasic health testing programs are operated commercially on a for-profit basis. Many of these do determine and report facts accurately. Some, however, give the appearance of encouraging individuals to be tested without a medical referral for the tests. Some indicate that when the results are compared against standards or norms the individual does not even have to see a physician. Some, in addition, perform a battery of tests which are not requested by an attending physician.

The physician's ethical responsibility is to provide his patient with high quality services. He should not utilize services of any testing program unless he has the utmost confidence in the quality of its services. He must assume professional responsibility for the best interest of the patient. As a professional man, the physician is entitled to compensation for his services. However, he should not be engaged in the commercial conduct of a testing or screening program and should not make a mark up commission or profit on services rendered by others. It is not, in itself, unethical for a physician to own an automated multiphasic facility or interest. The use the physician makes of this ownership may be unethical.

An attending physician may not receive a rebate, referral fee, or commission from a program whose facilities have been used by his patients.

An automated health testing facility is a fact finding and reporting system. It must be limited to fact finding and exclude interpretation. Findings disclosed must be interpreted only by physicians.

Offering a combination or medical and non-medical service to the public is to be avoided. The public may be confused as to what constitutes reporting a fact and what constitutes the making of a medical diagnosis.

A practicing physician may recommend multiphasic health testing where he believes it may be helpful to him in the care of his patient. Prudence dictates that the physician be selective in recommending or requiring patients to utilize the services of an automatic health testing facility and not adopt the practice of routinely requiring that all patients, or all new patients, undergo such testing. When good medical judgment suggests the

desirability of such testing, the physician should explain in general the nature and purpose of the testing. The patient must be afforded freedom to choose between automated multiphasic health testing facilities, if available. Alternatives in the way of single tests should be offered patients, where possible and practical.

An individual who is tested, or a facility which conducts these tests, may neither demand that a physician accept an individual as a patient nor evaluate the tests for the individual. The physician remains free to choose whom he will serve.

A physician employed by an automated multiphasic health testing facility, in conformity with well established policies, should not dispose of his professional attainments to any corporation or to a lay body under terms or conditions which permit the sale of the services of that physician by an agency for fee, nor allow his name or the prestige of his professional status as a physician to be used in the promotion of a commercial enterprise. He should neither aid nor abet an unlicensed individual or corporation to practice medicine.

There is a responsibility for the medical society to educate the public regarding indications for and against multiphasic health testing, to educate the membership of the society regarding ethical responsibilities in these matters, and the society must be ready to assist persons or corporations that seek advice in setting up multiphasic health testing facilities.

AMA Guidelines for Establishing and Operating Multiphasic Health Testing Programs

The following guidelines are recommended for use by physicians and medical societies in providing technical advice and assistance in the planning, development, implementation, and operation of multiphasic health testing programs:

1. Multiphasic health testing is a method of acquiring, storing, collating, and reproducing medical data on individual patients. The testing procedures are considered to be incomplete health services. Provisions must be made for a physician to interpret and evaluate this medical data base as an aid in continuing patient care.
2. The multiphasic testing program should meet applicable licensing requirements and be appropriately evaluated for quality control.
3. Physicians must be involved in the planning and development of testing programs.
4. The operation of all MHT programs must be supervised by qualified physicians at the testing center, particularly in regards to any abnormal findings, and these physicians must see that the patient is instructed to obtain medical advice for significant abnormal findings.
5. The system should be designed to make maximum use of allied health professionals and should utilize technical and automated techniques where justified.
6. For professional value and economic feasibility, the program should include tests that are simple, safe, easy to interpret, inexpensive and quick to perform, and that have acceptable sensitivity, specificity, high predictive value, and patient acceptance.
7. The testing system should include the following criteria: reliability, accuracy of output, saving of time of physicians and allied health personnel, adequate utilization, and sufficient flexibility for customization to physician and patient needs. The program should establish individual ethnic, geographic, and other variations of normal and abnormal patterns.
8. The program should provide for confidentiality of patient data.
9. The testing program should be used, where feasible, to meet otherwise unmet community health needs and should be integrated into the continuing health care system.
10. The testing program should be designed to meet various objectives such as diagnostic services, health maintenance, and guidance in management of ongoing illness including chronic disease.
11. Evaluation methodology should be built into the program to determine the acceptance and use, yield, false positives and false negatives, as well as the long-term effects of the program on illness and the need and demand for health services. The program should include a documented accounting system, at least for internal use, and a reasonable cost finding system that would allow for cost analysis and cost summaries.
12. The program should maintain freedom of choice for both the physician and the patient.

ISMS House of Delegates

OFFICIAL MEMBERS OF THE HOUSE WITH THE RIGHT TO VOTE

Officers of ISMS

President—J. M. Ingalls
502 Shaw Ave., Paris 61944
President-Elect—Joseph Skom
707 Fairbanks Ct., Chicago 60611
Secretary-Treasurer—Jacob E. Reisch
1129 S. Second St., Springfield 62704
First Vice President—Eli L. Borkon
14 Pinewood, Carbondale 62901
Second Vice President—Warren Young
3450 Haweswood Dr., Crete 60417
Speaker of the House—James A. McDonald
515 Oakwood Dr., Geneva 60134
Vice Speaker of the House—Herman Wing
400 E. Randolph St., Chicago 60601

Board of Trustees

Chairman, Board of Trustees—Joseph L. Bordenave
415 S. Second St., Geneva 60134
1st District—Joseph L. Bordenave 1977
415 S. Second St., Geneva 60134
1-A District—P. John Seward 1977
1601 Parkview, Rockford 61107
2nd District—Allan L. Goslin 1977
712 N. Bloomington St., Streator 61364
3rd District—Alfred Clementi 1976
675 W. Central Rd., Arlington Heights 60005
Robert T. Fox 1976
2136 Robin Crest, Glenview 60025
Henrietta Herbolsheimer 1978
5528 S. Hyde Park Blvd., Chicago 60637
Eugene T. Hoban 1978
6429 North Ave., Oak Park 60302
William M. Lees 1977
6518 N. Nokomis, Lincolnwood 60646
Joseph C. Sherrick 1977
303 E. Superior St., Chicago 60611
George Shropshear 1977
1525 E. 53rd St., Chicago 60615
Philip G. Thomsen 1977
13826 Lincoln, Dolton 60419
Frederick E. Weiss 1976
15643 Lincoln, Harvey 60426
4th District—Fred Z. White 1976
723 N. Second St., Chillicothe 61523
5th District—A. Edward Livingston 1976
326 Fairway Dr., Bloomington 61701
6th District—Robert R. Hartman 1978
1515A W. Walnut, Jacksonville 62650
7th District—Arthur Goodyear 1976
142 E. Prairie, Decatur 62523
8th District—Eugene P. Johnson 1976
P.O. Box 68, Casey 62420
9th District—Warren D. Tuttle 1978
203 N. Vine St., Harrisburg 62946
10th District—Julian W. Buser 1978
6600 W. Main St., Belleville 62223
11th District—Ross N. Hutchison 1977
126 E. 9th St., Gibson City 60936
Trustee-at-Large—Fredric D. Lake 1976
999 Michigan Ave., Evanston 60202

Representatives of County Societies

A complete listing of delegates and alternates to the ISMS House will appear with the convention program.

EX-OFFICIO MEMBERS OF THE HOUSE WITHOUT THE RIGHT TO VOTE

Past Presidents

J. Ernest Breed 1971
Everett P. Coleman 1945-1946
Edward W. Cannady 1970
Newton DuPuy 1968
Harlan English 1964
Edwin S. Hamilton 1962
H. Close Hesseltine 1961
Charles J. Jannings, III 1972
Frank J. Jirka, Jr. 1973
Fredric D. Lake 1975
Willis I. Lewis 1954
George F. Lull 1963
Burtis E. Montgomery 1966
Edward A. Piszczek 1965
Caesar Portes 1967
Willard C. Scrivner 1974
Leo P. A. Sweeney 1953
Philip G. Thomsen 1969
Arkell M. Vaughn 1955

Past Trustees

Earl H. Blair
Chicago, Trustee of the 3rd District
Walter C. Bornemeier
Chicago, Trustee of the 3rd District
Carl E. Clark
Sycamore, Trustee of the 1st District
Samuel Cloninger
64 Old Orchard, Skokie 60076
Herbert Dexheimer
Belleville, Trustee of the 10th District
David S. Fox
Chicago, Trustee of the 3rd District
Willard W. Fullerton
Sparta, Trustee of the 10th District
George E. Griffin
Princeton, Trustee of the 2nd District
Lee N. Hamm
Lincoln, Trustee of the 5th District
Ted LeBoy
Chicago, Trustee of the 3rd District
Joseph R. O'Donnell
Glen Ellyn, Trustee of the 11th District
Mather Pfeiffenberger
Alton, Trustee of the 6th District
Ralph N. Redmond
Sterling, Trustee from the 2nd District
Paul P. Youngberg
Moline, Trustee of the 4th District
Darrell H. Trumpe
Springfield, Trustee of the 5th District
William H. Schowengerdt
Champaign, Trustee of the 8th District
Charles K. Wells
Mt. Vernon, Trustee of the 9th District

Past Speakers

Walter C. Bornemeier, Chicago 1961-1964
Andrew J. Brislen 1974-1975
Edward W. Cannady, Belleville 1964-1967
Maurice M. Hoeltgen, Chicago 1967-1970
Paul W. Sunderland, Gibson City 1970-1973

ISMS DELEGATION TO THE AMA

Delegates

To Serve from Jan. 1, 1974 to Dec. 31, 1975
(Elected Mar. 28, 1973)

Jack Gibbs
175 S. Main St., Canton 61520
Theodore Grevas
2701-17th St., Rock Island 61201
Morgan M. Meyer
815 S. Main St., Lombard 60148
Edward A. Piszczek
6410 N. Leona Ave., Chicago 60646
Philip G. Thomsen
13826 Lincoln Ave., Dolton 60419
Fred A. Tworoger[1]
4753 N. Broadway, Chicago 60640

To Serve from Jan. 1, 1975 to Dec. 31, 1976
(Elected April 6, 1974)

Carl E. Clark
225 Edward St., Sycamore 60178
Alfred J. Faber
2110 Swainwood Dr., Glenview 60025
H. Close Hesseltine
5807 S. Dorchester Ave., Chicago 60637
Maurice M. Hoeltgen
4700 W. 95th St., Oak Lawn 60453
William M. Lees
6518 N. Nokomis Ave., Lincolnwood 60646
John J. Ring[2]
511 E. Hawley St., Mundelein 60060
Charles K. Wells
117 N. 10th St., Mt. Vernon 62864

To Serve from Jan 1, 1976 to Dec. 31, 1977
(Elected April 5, 1975)

Howard C. Burkhead
130 Dempster St., Evanston 60202
Jack Gibbs
175 S. Main St., Canton 61520
Theodore Grevas
2701-17th St., Rock Island 61201
Morgan M. Meyer
815 S. Main St., Lombard 60148
Edward A. Piszczek
6410 N. Leona Ave., Chicago 60646
Fred A. Tworoger
4753 N. Broadway, Chicago 60640

Honorary Delegates

Walter C. Bornemeier
19273 Harleigh Dr., Saratoga, Cal. 95070
Edwin S. Hamilton
985 Cobb St., Kankakee 60901
Frank J. Jirka, Jr.
1507 Keystone Ave., River Forest 60305
George F. Lull
2440 Lakeview Ave., Chicago 60614
Burtis E. Montgomery
37 S. Main St., Harrisburg 62946

Delegation Chairman: Edward A. Piszczek; Secretary: Jack Gibbs

Alternate Delegates

To Serve from Jan. 1, 1974 to Dec. 31, 1975
(Elected Mar. 28, 1973)

Herschel Browns
4600 N. Ravenswood Ave., Chicago 60640
Allison L. Burdick, Jr.
1637 N. Mobile Ave., Chicago 60639
J. M. Ingalls
502 Shaw Ave., Paris 61944
Joseph R. O'Donnell
444 Park Blvd., Glen Ellyn 60137
George Shropshear
1525 E. 53rd St., Chicago 60615
Glen Tomlinson
4 Professional Park, Lincoln 62656
George T. Wilkins[3]
1204-27th St., Granite City 62040

To Serve from Jan. 1, 1975 to Dec. 31, 1976
(Elected April 6, 1974)

David S. Fox[4]
826 E. 61st St., Chicago 60637
Lawrence L. Hirsch[5]
Chicago Medical School, Downey 60064
Robert P. Johnson[6]
108 Maple Grove, Springfield 62707
Fredric D. Lake
999 Michigan Ave., Evanston 60202
Eugene T. Leonard
3 Crestwood Lane, Rockford 61107
Theodore R. Van Dellen
200 E. Chestnut St., Chicago 60611

To Serve from Jan 1, 1976 to Dec. 31, 1977
(Elected April 5, 1975)

Herschel Browns
4600 N. Ravenswood Ave., Chicago 60640
Allison L. Burdick, Jr.
1637 N. Mobile Ave., Chicago 60639
J. M. Ingalls
502 Shaw Ave., Paris 61944
Joseph R. O'Donnell
444 Park Blvd., Glen Ellyn 60137
George Shropshear
1525 E. 53rd St., Chicago 60615
Glen Tomlinson
4 Professional Park, Lincoln 62656
George T. Wilkins
1204-27th St., Granite City 62040

[1] *Elected to fill unexpired term of Frank J. Jirka, Jr.*
[2] *Elected to 13th delegate position*
[3] *Elected to fill unexpired term of Paul W. Sunderland*
[4] *Elected to fill unexpired term of Fred A. Tworoger*
[5] *Elected to 13th alternate delegate position*
[6] *Elected to fill unexpired term of John J. Ring*

Officers of County Medical Societies 1975

County	President	Secretary
Adams Members: 92-Dist. 6 Thomas D. Hanstrom, Ex. Sec. 1118 Broadway Quincy 62301	Leonard D. Grayson 1101 Maine, Quincy 62301	Julio del Castillo 1124 Broadway, Quincy 62301
Alexander Members: 7-Dist. 10	Lewis Ent 309 8th St., Cairo 62914	Charles L. Yarbrough 800 Commercial, Cairo 62914
Bond Members: 7-Dist. 7	James R. Goggin 207 N. 2nd St., Greenville, 62246	M. Kenneth Kaufmann 105 E. College, Greenville 62246
Boone Members: 14-Dist. 1A	Adrian Schreiber Caledonia 61011	Earl S. Davis 119 So. State, Belvidere 61008
Bureau Members: 30-Dist. 2	Kent Monroe 207 E. St. Paul, Spring Valley 61362	K. Dexter Nelson 101 Park Ave., Princeton 61356
Carroll Members: 9-Dist. 1A	Eliseo M. Colli 102 E. Washington, Mt. Carroll 61053	Basilios Lambos Broad St., Lanark 61046
Cass-Brown Members: 5-Dist. 6	R. A. Spencer 115 W. 4th St., Beardstown 62618	B. A. DeSulis 115 W. 4th St., Beardstown 62618
Champaign Members: 194-Dist. 8 Larry Booth, Ex. Sec. 407 S. 4th St. Champaign 61820	Stanley Smith Carle Clinic, Urbana 61801	H. Ewing Wachter 2108 W. Springfield, Champaign 61820
Christian Members: 20-Dist. 7	I. Del Valle 311 S. Main St., Taylorville 62568	J. W. Murphy 301 S. Webster, Taylorville 62568
Clark Members: 6-Dist. 8	Howard G. Johnson Casey Medical Center, Casey 62420	James R. Buechler 410 N. Second, Marshall 62441
Clay Members: 8-Dist. 7	A. Paul Naney Flora Clinic, Flora 62839	Donald L. Bunnell Flora Clinic, Flora 62839
Clinton Members: 13-Dist. 7	Renato B. Rivera 1280 13th St., Carlyle 62231	F. H. Ketterer 289 N. Main St., Breese 62230
Coles-Cumberland Members: 36-Dist. 8	Byron Ruskin Memorial Hospital, Mattoon 61938	J. D. Heath 6 Orchard Dr., Charleston 61920
Cook Members: 7407-Dist. 3 Robt. Lindley, Ex. Adm. 310 S. Michigan Ave. Chicago, Ill. 60604	David S. Fox 826 E. 61st St., Chicago 60637	Arthur R. Fischer 1845 Ridgeland, Berwyn 60402
Crawford Members: 14-Dist. 8	Dean Pelley Allen Clinic, Robinson 62454	W. B. Schmidt 408 S. Cross, Robinson 62454
De Kalb Members: 57-Dist. 1A	Dean A. Miller 232 S. 2nd St., DeKalb 60115	Thomas E. Kirts 232 S. 2nd St., DeKalb 60115
De Witt Members: 11-Dist. 5	John W. Veirs 219 E. Main St., Clinton 61727	George Castrovillo 109 S. Main, Farmer City 61842
Douglas Members: 10-Dist. 8	R. N. Arrol 126 S. Locust, Arcola 61910	Max Johnson Newman 61942

County	President	Secretary
DuPage Members: 486-Dist. 11 Lillian Widmer, Ex. Sec. 646 Roosevelt Road Glen Ellyn, Ill. 60137	Orren D. Baab 550 N. Monroe, Hinsdale 60521	James P. Campbell 322 N. Blanchard St., Wheaton 60187
Edgar Members: 15-Dist. 8	J. R. Shackelford 502 Shaw, Paris 61944	J. M. Ingalls Medical Center Clinic, Paris 61944
Edwards Members: 2-Dist. 9	Paul S. Neirenberg 7 W. Main St., Albion 62806	Andrew Krajec Box 336, West Salem 62476
Effingham Members: 22-Dist. 7	L. Beis 702 W. Kentucky, Effingham 62401	John A. Chalstrom 416 W. Virginia, Effingham 62401
Fayette Members: 7-Dist. 7	D. H. Rames 1029 N. 8th, Vandalia 62471	Hans Rollinger 1003 N. 8th St., Vandalia 62471
Ford Members: 11-Dist. 11	William A. Garrett Sibley 61773	Paul W. Sunderland 214 N. Sangamon, Gibson City 60936
Franklin Members: 23-Dist. 9	Loren L. Love 6 Hillcrest Dr., Christopher 62822	D. P. Richerson P.O. Box 99, Christopher 62822
Fulton Members: 29-Dist. 4	Robert W. Ridley 175 S. Main, Canton 61520	Marvin E. Schmidt 210 W. Walnut, Canton 61520
Gallatin Members: 1-Dist. 9		John E. Doyle Ridgway 62979
Greene Members: 7-Dist. 6	Ludwig Dech 132 W. Lorton, Roodhouse 62082	James C. Reid Fillager Mem. Clinic, Greenfield 62044
Hancock Members: 9-Dist. 4	Werner Schoenherr Bowen 62316	James E. Coeur 630 Locust, Carthage 62321
Henderson Members: 1-Dist. 4		Silvino Lindo, Jr. Biggsville 61448
Henry-Stark Members: 31-Dist. 4	Lawrence N. Wathier 119½ S. State, Geneseo 61254	David E. Stearns 513 Elliott, Kewanee 61443
Iroquois Members: 18-Dist. 11	Harry Barnett P.O. Box 128, Ashkum 60911	Tsong-Chou Lee Clifton 60927
Jackson Members: 67-Dist. 10	Masood Akhtar 18 N. 11th St., Murphysboro 62966	Paul Lorenz P.O. Box 2347, Carbondale 62901
Jasper Members: 2-Dist. 8	Don L. Hartrich 1211 W. Jourdan, Newton 62448	Monico Low 609 S. Van Buren, Newton 62448
Jefferson-Hamilton Members: 32-Dist. 9	Gerald E. Fox 1 Doctors Park Rd., Mt. Vernon 62864	Antonio Boba P.O. Box 643, Mt. Vernon 62864
Jersey-Calhoun Members: 9-Dist. 6	Bernard Baalman Medical Center, Hardin 62047	Clyde Wieland Maple Summit Rd., Jerseyville 62052
Jo Daviess Members: 7-Dist. 1A	Wilbur E. Johnson Galena 61036	Lyle A. Rachuy 323 N. Main St., Stockton 61085
Kane Members: 283-Dist. 1 Michael Wild, Ex. Dir. 11 So. 2nd St. Geneva, Ill. 60134	Emanuel M. Herzon 860 Summit St., Elgin 60120	David J. Clark 1870 W. Galena Blvd., Aurora 60506
Kankakee Members: 101-Dist. 11	Preston W. Sawyer 70 Meadowview Center, Kankakee 60901	A. A. Palow 555 So. Schuyler, Kankakee 60901
Kendall Members: 7-Dist. 11	Victor Smith Newark 60541	John P. Cullinan Oswego 60543
Knox Members: 63-Dist. 4	F. P. Weyrens 3315 N. Seminary, Galesburg 61401	R. B. Howell 1708 N. Prairie, Galesburg 61401

County	President	Secretary
Lake Members: 287-Dist. 1 Julia Schulz, Ex. Sec. P.O. Box 148 Gurnee, Ill. 60031	David Helberg 1702 Washington, Waukegan 60085	Joseph L. Burke 2504 Washington, Waukegan 60085
LaSalle Members: 102-Dist. 2	William E. Erkonen 308 E. Kent, Streator 61364	Allan L. Goslin 712 N. Bloomington, Streator 61364
Lawrence Members: 10-Dist. 8 Ruth Gariepy, Ex. Sec. Lawrence City Mem. Hosp. Lawrenceville, Ill. 62439	Gilbert Miller North Main St., Bridgeport 62417	Alexander Po R.R. #2, Lawrenceville 62439
Lee Members: 21-Dist. 1A	Michael Hong 403 E. 1st St., Dixon 61021	Samuel Adler N. Ottawa Dr., Dixon 61021
Livingston Members: 28-Dist. 2	Leslie Lowenthal 420 N. Plum, Pontiac 61764	Karl T. Deterding 612 E. Water St., Pontiac 61764
Logan Members: 21-Dist. 5	Glen Tomlinson #4 Doctor's Park, Lincoln 62656	Robert Brown Perry 311 8th St., Lincoln 62656
Macon Members: 149-Dist. 7 Mary J. Bretz, Ex. Sec. 1800 E. Lake Shore Dr. Decatur, Ill. 62521	Otto Brosius 2300 N. Edward, Decatur 62521	William C. Simon 1807 N. Edward St., Decatur 62521
Macoupin Members: 20-Dist. 6	Robert H. Rutherford 224 E. Main St., Carlinville 62626	Robert England 224 E. Main, Carlinville 62626
Madison Members: 152-Dist. 6	Nancy Voege 307 Henry, Alton 62002	Norman E. Taylor 95 S. 9th St., E. Alton 62024
Marion Members: 39-Dist. 7	S. E. Rubio Box 609, Salem 62881	W. P. Plassman Box 552, Centralia 62801
Mason Members: 6-Dist. 5		Henry W. Maxfield Mason City 62664
Massac Members: 4-Dist. 9	James L. Bremer 805 Market, Metropolis 62960	
McDonough Members: 27-Dist. 4	Daniel Mazar 129 E. Hurst, Bushnell 61422	Stephan L. Roth Box 258, Colchester 62326
McHenry Members: 78-Dist. 1 Evelyn Rosulek, Ex. Sec. 308 E. Kimball Ave. Woodstock, Ill. 60098	William R. Larsen 13707 W. Jackson, Woodstock 60098	Daniel E. Horan 527 W. South St., Woodstock 60098
McLean Members: 95-Dist. 5 Mrs. Cathy Sengpiel Exec. Sec. 401 W. Virginia Normal, Ill. 61761	George Irwin 401 W. Virginia, Normal 61761	Douglas R. Bey 401 W. Virginia, Normal 61761
Menard Members: 1-Dist. 5	Robert J. Schafer 116 N. 5th, Petersburg 62675	Robert J. Schafer 116 N. 5th St., Petersburg 62675
Mercer Members: 4-Dist. 4	R. N. Svendsen 209 S. College, Aledo 61231	Monty P. McClellan 309 NW 2nd, Aledo 61231
Monroe Members: 8-Dist. 10	I. Kremer 854 W. Bottom, Columbia 62236	Edelberto Maglasang 109 W. Legon, Columbia 62236
Montgomery Members: 20-Dist. 5	L. George Allen 400 N. Monroe, Litchfield 62056	James T. Foster 8 Arrowhead Rd., Litchfield 62056

County	President	Secretary
Morgan-Scott Members: 38-Dist. 6	Francis J. Vincent 1515 W. Walnut, Jacksonville 62650	R. H. Kooiker 1600 W. Walnut, Jacksonville 62650
Moultrie Members: 5-Dist. 7	Phillip Best 14 N. Washington, Sullivan 61951	Dean McLaughlin 112 E. Harrison, Sullivan 61951
Ogle Members: 17-Dist. 1A	L. T. Koritz 324 Lincoln Hgwy., Rochelle 61068	Russell Zack 915 Caron Rd., Rochelle 61068
Peoria Members: 278-Dist. 4 David W. Meister, Jr. Ex. Vice-Pres. 427 1st National Bk. Bldg. Peoria, Ill. 61602	Karl R. Sohlberg 427 1st National Bk. Bldg., Peoria	Joseph O. Dean, Jr. 427 1st National Bk. Bldg., Peoria
Perry Members: 18-Dist. 10	Gene Stotlar Medical Arts Bldg., Pinckneyville 62274	Bill R. Fulk 207 E. Main, DuQuoin 62832
Piatt Members: 6-Dist. 7	George Green 121 N. State, Monticello 61856	Joseph Allman 121 N. State, Monticello 61856
Pike Members: 8-Dist. 6	T. C. Bunting 321 W. Washington, Pitsfield 62363	B. J. Rodriguez 868 Mortimer, Barry 62312
Pulaski Members: 1-Dist. 10	A. L. Robinson Box 277, Mounds 62964	
Randolph Members: 20-Dist. 10	L. C. Fiene W. Belmont St., Sparta 62286	C. S. Schlageter 818 E. Broadway, Sparta 62286
Richland Members: 27-Dist. 8	I. Keith Edwards 1200 N. East St., Olney 62450	Lawrence J. Knox 1200 N. East St., Olney 62450
Rock Island Members: 166-Dist. 4 James A. Koch, Ex. Sec. 612 Kahl Bldg. Davenport, Iowa 52801	George Burke 2701 17th St., Rock Island 61201	Earl H. Clark 2701 17th St., Rock Island 61201
St. Clair Members: 220-Dist. 10 Ed Belz, Exec. Sec. 4825 W. Main Belleville, Ill. 62223	Mays Maxwell P.O. Box 1250, E. St. Louis 62222	Donald Jerome 301 W. Lincoln, Belleville 62221
Saline-Pope-Hardin Members: 29-Dist. 9	Gary D. Cody 1201 Pine St., Eldorado 62930	Warren R. Dammers P.O. Box 281, Harrisburg 62946
Sangamon Members: 242-Dist. 5 L. R. Brosi, Ex. Dir. 2100 Lindsay Rd. Springfield, Ill. 62704	Gerald T. Riordan 613 N. 7th St., Springfield 62702	Robert L. Prentice 701 N. Walnut, Springfield 62702
Schuyler Members: 3-Dist. 4	R. R. Dohner 103 W. Washington, Rushville 62681	Henry C. Zingher West Side Square, Rushville 62681
Shelby Members: 7-Dist. 7	H. H. Pettry 407 W. Main St., Shelbyville 62565	Otto G. Kauder P.O. Box 395, Shelbyville 62565
Stephenson Members: 51-Dist. 1A	Robert L. Rockey 3103 W. Stephenson, Freeport 61032	Roger Jinkins 1262 W. Stephenson, Freeport 61032
Tazewell Members: 47-Dist. 5 David W. Meister, Jr., Exec. Sec. 427 1st National Bk. Bldg. Peoria, Ill. 61602	John B. Sombeck 427 1st National Bk. Bldg., Peoria	Robert M. Wright 427 1st National Bk. Bldg., Peoria
Union Members: 6-Dist. 10	Robert L. Rader 200 N. Main St., Anna 62906	William H. Whiting Box 410, Anna 62906

County	President	Secretary
Vermilion Members: 94-Dist. 8	W. F. Hensold 7 N. Virginia Ave., Danville 61832	L. W. Tanner 7 N. Virginia, Danville 61832
Wabash Members: 7-Dist. 9	Roger Fuller 1123 Chestnut, Mt. Carmel 62863	C. L. Johns 114 W. 5th St., Mt. Carmel 62863
Warren Members: 11-Dist. 4	W. Roller 309 S. Main, Monmouth 61462	Glenn W. Chamberlin 219 E. Euclid, Monmouth 61462
Washington Members: 2-Dist. 10	Charles Longwell 111 S. Washington, Nashville 62263	Jerry L. Beguelin Box 197, Irvington 62848
Wayne Members: 7-Dist. 9	C. J. Jannings, III 301 N.W. 11th St., Fairfield 62837	S. W. Konarski 101 E. Center St., Fairfield 62837
White Members: 8-Dist. 9	J. G. Harrell Carmi 62821	J. A. Stricklin Carmi 62821
Whiteside Members: 43:-Dist. 1A	William G. Manalo 911 Albany, Erie 61250	Timothy B. Sullivan, Jr. 1716 Locust, Sterling 61081
Will-Grundy Members: 199-Dist. 11 Lawrence F. Moore, Ex. Sec. 58 N. Chicago St. Joliet 60431	Albert W. Ray 58 N. Chicago St., Joliet 60431	Stephen E. Copp 58 N. Chicago, Joliet 60431
Williamson Members: 30-Dist. 9	Daniel Roth 201 South 14th, Herrin 62948	Herbert V. Fine 110 N. Division, Carterville 62918
Winnebago Members: 315-Dist. 1A Mrs. Johanna Lund Exec. Adm. 310 N. Wyman St. Rockford, Ill. 61101	Miles J. Gullickson 310 N. Wyman St., Rockford 61101	John English 310 N. Wyman St., Rockford 61101
Woodford Members: 7-Dist. 2	H. W. Riggert Metamora 61548	James W. Riley 109 S. Major, Eureka 61530

No Organized County Society

Johnson
Marshall
Putnam

Joint County Societies

Cass-Brown
Coles-Cumberland
Henry-Stark
Jefferson-Hamilton
Jersey-Calhoun
Morgan-Scott
Saline-Pope-Hardin
Will-Grundy

A major portion of this listing may become obsolete as of January, 1976. An up-to-date listing will be published in the delegates handbook section of the March issue of the Illinois Medical Journal.

ISMS Annual Meeting

April 25-29, 1976

The Palmer House **Chicago**



TRUSTEE DISTRICTS

TRUSTEE DISTRICT COMMITTEES

First District

Joseph L. Bordenave, Geneva, *Trustee*
Counties of Kane, Lake, McHenry

Ethical Relations Committee	Term Expires
David Clark, Aurora	1978
Emanuel Herzon, Elgin	1978
Gerald Liesen, St. Charles	1976
A. M. Rosetti, McHenry	1977

Peer Review Committee	
David Helberg, Waukegan	1978
Eugene Pitts, Waukegan	1978
James Pritchard, Geneva	1978
Peter Vinceguerra, Libertyville	1978

1-A District

P. John Seward, Rockford, *Trustee*
Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago

Ethical Relations Committee	Term Expires
John H. Steinkamp, Belvidere, *Chairman*	1978

Peer Review Committee	
Robert Behmer, Rockford, *Chairman*	1977
Frank Luedke, DeKalb	1978
John E. Maddon, Freeport	1976

Second District

Allan L. Goslin, Streator, *Trustee*
Counties of Bureau, LaSalle, Livingston, Marshall, Putnam, Woodford

Ethical Relations Committee	Term Expires
K. Dexter Nelson, Princeton, *Chairman*	1977
William Erkonen, Streator	1978
Tim Sullivan, Sterling	1976

Peer Review Committee	
Louis Tarsinos, Princeton, *Chairman*	1976
James B. Aplington, LaSalle	1976
Francis J. Brennan, Utica	1976
Silvio Davito, Spring Valley	1976
Bernard J. Doyle, LaSalle	1976
William Ehling, Streator	1977
P. Lymberopoulis, Princeton	1976
Rowland Musick, Mendota	1976
Theodore Mauger, Chatsworth	1978
Theodore W. Wagenknecht, Streator	1976

Third District

Alfred Clementi, Arlington Heights, *Trustee*
Robert T. Fox, Glenview, *Trustee*
Henrietta Herbolsheimer, Chicago, *Trustee*
Eugene T. Hoban, Oak Park, *Trustee*
William M. Lees, Lincolnwood, *Trustee*
Joseph C. Sherrick, Chicago, *Trustee*
George Shropshear, Chicago, *Trustee*
Philip G. Thomsen, Dolton, *Trustee*
Frederick E. Weiss, Harvey, *Trustee*

Fourth District

Fred Z. White, Chillicothe, *Trustee*
Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Warren

Ethical Relations Committee	Term Expires
Richard Icenogle, Roseville, *Chairman*	1977
John Bowman, Abingdon	1976
George Burke, Rock Island	1978

Peer Review Committee	
Russell Jensen, Monmouth, *Chairman*	1976
William Daugherty, Moline	1978
Donald Dexter, Macomb	1977
G. W. Geibelhausen, Peoria	1978
James C. Parsons, Geneseo	1976
Clarence Ward, Peoria	1978

Fifth District

A. Edward Livingston, Bloomington, *Trustee*
Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon, Tazewell

Ethical Relations Committee	Term Expires
William W. Curtis, Springfield, *Chairman*	1977
Jack Means, Mason City	1978
A. L. Van Ness, Bloomington	1976

Peer Review Committee	
James Borgerson, Mt. Pulaski, *Chairman*	1977
Robert Price, Bloomington, *Co-Chairman*	1977
George Irwin, Bloomington	1976
Paul Lafata, Springfield	1977
John G. Meyer, Springfield	1978
Alton J. Morris, Springfield	1976
Robert B. Perry, Lincoln	1976
Robert Schaefer, Petersburg	1978
James Weimer, Pekin	1976

Sixth District

Robert R. Hartman, Jacksonville, *Trustee*
Counties of Adams, Brown, Calhoun, Cass, Green, Jersey, Macoupin Madison, Morgan, Pike, Scott

Ethical Relations Committee	Term Expires
Newton DuPuy, Quincy, *Chairman*	1977
Bernard Baalman, Hardin	1978
Edward K. DuVivier, Alton	1977
Joseph J. Grandone, Gillespie	1977

Peer Review Committee	
James Reid, Greenfield, *Chairman*	1977
Meyer Shulman, Pittsfield, *Co-Chairman*	1977
E. C. Bone, Jacksonville	1976
Robert England, Carlinville	1978
Robert C. Murphy, Quincy	1976
Frank B. Norbury, Jacksonville	1978
Edward Ragsdale, Alton	1977
James Sutherland, Quincy	1977

Seventh District

Arthur F. Goodyear, Decatur, *Trustee*
Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby

Ethical Relations Committee	Term Expires
Carl Sandburg, Decatur, *Chairman*	1976
C. R. Daisy, Greenville	1978

Peer Review Committee	
Stanley Moore, Vandalia, *Chairman*	1976
M. K. Kaufman, Greenville	1977
H. Gale Zacheis, Decatur	1977
Walter P. Plassman, Centralia	1976
William Sargeant, Effingham	1976

Eighth District

Eugene P. Johnson, Casey, *Trustee*
Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermillion

Ethical Relations Committee	Term Expires
Mack W. Hollowell, Charleston, *Chairman*	1977
James H. Pass, Olney	1978
Alan M. Taylor, Danville	1976

Peer Review Committee	
E. T. Baumgart, Danville, *Chairman*	1977
James W. Landis, Olney, *Co-Chairman*	1977
E. A. Kendall, Mattoon	1976
George T. Michell, Marshall	1978
Gordon Sprague, Paris	1976

Ninth District

Warren D. Tuttle, Harrisburg, *Trustee*
Counties of Edwards, Franklin, Gallatin, Hamilton, Hardin, Jefferson, Johnson, Massac, Pope, Saline, Wabash, Wayne, White, Williamson

Ethical Relations Committee	Term Expires
Andrew Krajec, West Salem, *Chairman*	1976
Antonio Boba, Mt. Vernon	1977
Elliott Partridge, Eldorado	1977

Peer Review Committee	
C. J. Jannings, III, Fairfield, *Chairman*	1976
Philip D. Boren, Carmi	1977
Herbert V. Fine, Carterville	1978
Harry L. Lewis, Benton	1978
Ernest Lowenstein, Mt. Carmel	1976
Charles K. Wells, Mt. Vernon	1978

Tenth District

Julian W. Buser, Belleville, *Trustee*
Counties of Alexander, Jackson, Monroe, Perry, Pulaski, Randolph, St. Clair, Union, Washington

Ethical Relations Committee	Term Expires
A. L. Robinson, Mounds, *Chairman*	1976
William Borgsmiller, Murphysboro	1978
Peter Soto, Belleville	1977

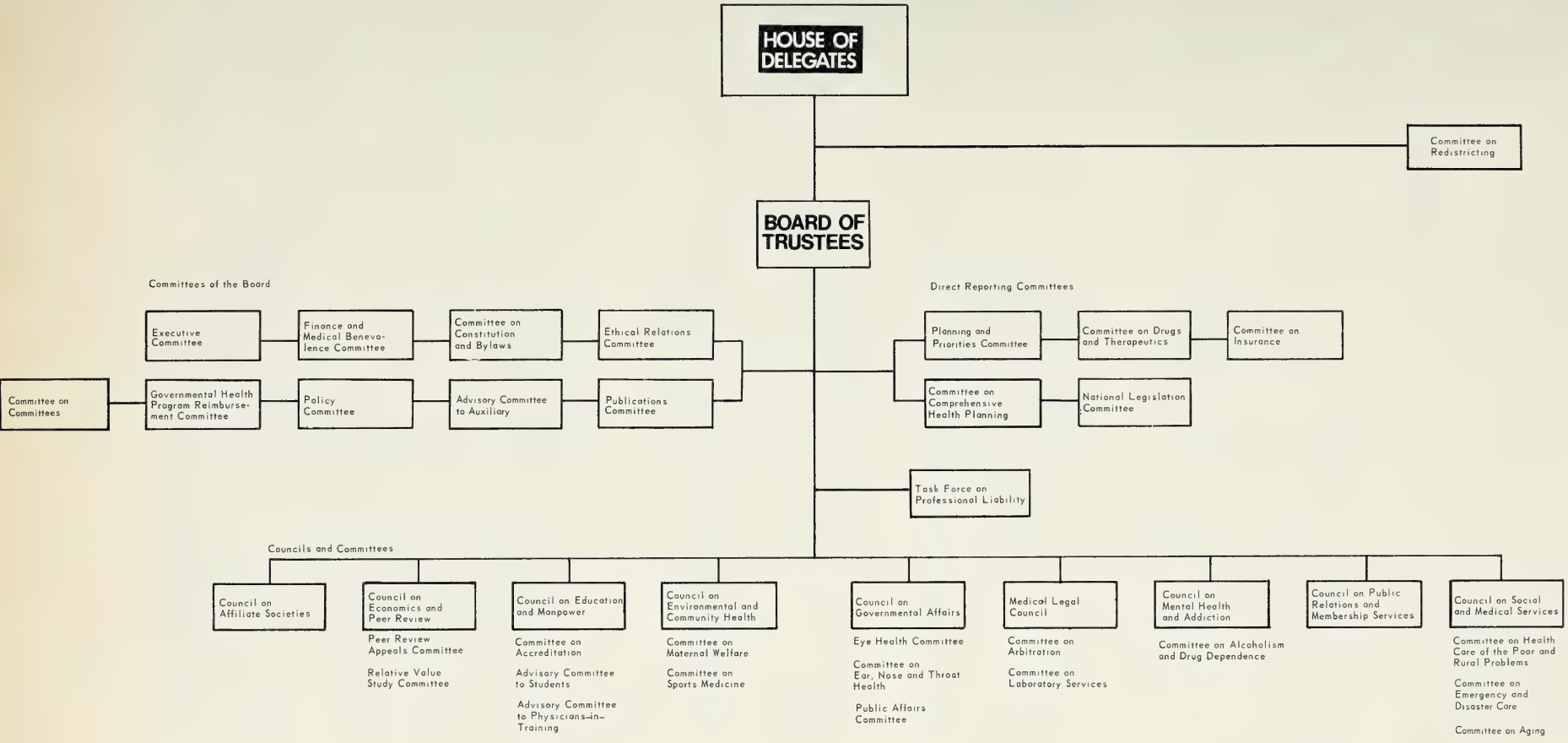
Peer Review Committee	
Joseph A. Petrazio, Murphysboro, *Chairman*	1976
Charles Baldree, Belleville	1976
Eli Borken, Carbondale	1976
R. W. Jost, Waterloo	1978
B. Kinsman, DuQuoin	1976
Robert Rader, Anna	1977
R. E. Schettler, Red Bud	1977
William H. Walton, Belleville	1978
Charles L. Yarbrough, Cairo	1976

Eleventh District

Ross N. Hutchison, Gibson City, *Trustee*
Counties of DuPage, Ford, Grundy, Iroquois, Kankakee, Kendall, Will

Ethical Relations Committee	Term Expires
James Ryan, Kankakee, *Chairman*	1978
John Bowden, Joliet	1976
Lawrence D. Lee, Manhattan	1976

Peer Review Committee	
James Campbell, Wheaton, *Chairman*	1978
James E. Dailey, Watseka	1978
James Lambert, Joliet	1976
Guy Pandola, Joliet	1978
William C. Perkins, West Chicago	1976
A. G. Parkhurst, Kankakee	1977
W. H. Brill, Oswego	1977



Groups Related to ISMS

- Illinois Foundation for Medical Care
- Illinois Council on Continuing Medical Education
- ISMS Education and Scientific Foundation
- Student Loan Fund Board

ISMS Representation to other Groups

- Swanberg Foundation
- Long Term Care Advisory Council to IDPH
- Midwest Regional Library Association
- Ill. Society, American Association of Medical Assistants
- Ill. Council of Home Health Agencies
- Chicago Alliance for VD Awareness
- Bar Associations–Interprofessional Code
- Drug Abuse Council of Illinois
- Pediatric Coordinating Council
- Joint Committee on School Health
- Ill. Interagency Council on Smoking and Disease
- IDPH/CHP Planning Committee on Perinatal Mortality
- ISMS/IPS Peer Review Consulting Committee
- U.S. Pharmacopeia
- M.D. Committee on Optometry
- School Health Physicals Task Force–CHP
- The Commission on Children
- INA/ISMS Joint Practice Comm.
- Council of Emergency Care Organizations
- Ill. Regional Medical Program
- Medicolegal Committee, Ill. Medical Records Assn.

Councils of the Illinois State Medical Society

Councils of the Illinois State Medical Society are appointed by the Chairman of the Board of Trustees subject to approval of the Board of Trustees. The councils are composed of such members as are necessary to accomplish the purposes of the council. Some committees are composed of members of the Board of Trustees and are designated Board Committees. Some free standing committees may report directly to the board and may not be assigned to a council. Task Forces are established to address a particular problem or concern which crosses areas of responsibility of the several councils. The task forces report directly to the board, as do representatives to various other agencies. The President, President-Elect, Speaker of the House, and Chairman of the Board are, by virtue of their office, ex-officio members of all groups.

COUNCIL ON AFFILIATE SOCIETIES

Robert Bettasso, *Chairman*
Ill. Chap., Amer. Coll. of Surgeons
1703 Polaris Circle, Ottawa 61350
Lawrence Breslow
Ill. Chap., Amer. Academy of Pediatrics
1500 Sherman Rd., Northbrook 60062
Edward Brunner
Ill. Soc. of Anesthesiologists
303 E. Chicago Ave., Chicago 60611
James Burden
Chicago Urological Society
720 N. Michigan, Chicago 60611
Ivan Ciric
Ill. Neurosurgical Society
2500 Ridge Ave., Evanston 60201
John Coleman
Ill. Society of Internal Medicine
7939 S. Western, Chicago 60620
Norman M. Frank
Ill. Chap., Amer. Academy of Family Phy.
421 Park Ave., Clarendon Hills 60514
Jack L. Gibbs
Ill. Surgical Society
175 Main St., Canton 61520
B. Jay Hill
Ill. Radiological Society
23 W. 153 Red Oak Dr., Glen Ellyn 60137
Gerald G. Hoffman
Ill. Society of Pathology
660 N. Westmoreland Rd., Lake Forest 60045
John J. McLaughlin
Ill. OB-GYN Society
2100 Glenwood, Joliet 60435
Robert C. Muehrcke
Ill. Chap., Amer. College of Physicians
518 N. Austin Blvd., Oak Park 60302
Charles Mullenix
Ill. Assoc. of Ophthalmology
1775 Glenview Rd., Glenview 60025
David L. Rosenberg
Ill. Psychiatric Society
1893 Sheridan Rd., Highland Park 60035
William H. Schwingel
Ill. Orthopedic Society
1240 N. Highland, Aurora 60506
Bill B. Smiley
Ill. Chap., Amer. Coll. of Emer. Phy.
2155 Hoyt Ct., Decatur 62526
E. B. Sylvester
Ill. Section, Amer. Coll. of OB-GYN
57 N. Ottawa, Joliet 60431

CONSULTANT:
Fredric D. Lake

ALTERNATE:
Albert L. Pisani
Ill. Chap., American Academy of Pediatrics
40 So. Clay St., Hinsdale 60521

STAFF: Jeffrey M. Holden

Responsibilities and Purposes:
To improve communication and provide liaison with the specialty societies; provide specialty consultation to other ISMS councils and committees; and to serve as a resource unit to ISMS on advances in the medical specialties.

COUNCIL ON ECONOMICS AND PEER REVIEW

Joseph R. O'Donnell, *Chairman*
444 Park, Glen Ellyn 60137
Earl E. Fredrick, Jr.
10830 Halsted, Chicago 60628
Homer Goldstein
P.O. Box G, Libertyville 60048
A. Beaumont Johnson
860 Summit, Elgin 60120
Martin P. Meisenheimer
605 W. Central Rd., Arlington Heights 60005
Michael Murray
1200 N. East, Olney 62450
Herbert Natof
1710 Cloverdale, Highland Park 60035
Luke R. Pascale
18668 Dixie Highway, Homewood 60430
Joseph Silverstein
1616 Sheridan Rd., Wilmette 60091
Alex Spadoni
2301 Glenwod Ave., Joliet 60435
Cyril Wiggishoff
25 E. Washington St., Chicago 60602
Ben Williams
1400 W. Park Ave., Urbana 61801

CONSULTANTS:
Warren Young
3450 Haweswood Dr., Crete 60417
Eli Borkon
14 Pinewood, Carbondale 62901

STAFF: Alexander R. Lerner

Committees:
Peer Review Appeals
Relative Value Study

Responsibilities and Purposes:
The Council on Economics & Peer Review shall concern itself with: 1) relations with the health insurance industry and prepayment plans; 2) fees and fee adjudication as promulgated by the ISMS; 3) health care cost and utilization; 4) new modes of health care delivery (HMOs, prepaid programs); 5) health care planning programs (CHP) and 6) serving as the appellate body for peer review in the state.

PEER REVIEW APPEALS COMMITTEE

Council Members:
Earl E. Fredrick, Jr., *Chairman*
A. Beaumont Johnson
Martin P. Meisenheimer
Michael Murray
Cyril C. Wiggishoff
STAFF: Larry S. Boress

Responsibilities and Purposes:
The Peer Review Appeals Committee serves as the appellate body for peer review in the state. It considers cases being appealed from local or district Peer Review committees involving quality and quantity of medical care. The committee also serves as liaison to local peer review committees and offers its assistance whenever requested.

RELATIVE VALUE STUDY COMMITTEE

Council Member:
Ben Williams, *Chairman*

Non-Council Members:
Robert K. Anzinger
333 E. Ontario, Chicago 60611
Joseph L. D'Silva
513 Kin Court, Wilmette 60091
John L. Eaton
2855-18th St., C., Moline 61265

CONSULTANTS:
Alfred Clementi
675 W. Central Rd., Arlington Heights 60004
Jacob E. Reisch
1129 S. 2nd St., Springfield 62704
STAFF: Larry S. Boress

Responsibilities and Purposes:
The Committee's purpose is a positive effort to develop an Illinois relative value study.

COUNCIL ON EDUCATION AND MANPOWER

Morgan M. Meyer, *Chairman*
815 S. Main, Lombard 60148
Carl R. Barthelemy
175 S. Main, Canton 61520
Milda Budrys
990 Lake Shore Dr., Apt. 10B, Chicago 60611
Allison L. Burdick, Jr.
1637 N. Mobile, Chicago 60639
William Durham
203 N. Vine St., Harrisburg 62946
N. Kenneth Furlong
221 N.E. Glen Oak Ave., Peoria 61603
Larry C. Gunn
40 S. Clay, Hinsdale 60521
Lawrence L. Hirsch
Chicago Medical School, Downey 60064
Gonzalo Ruiz
2551 North Milwaukee, Chicago 60647
Joseph R. Shackelford
502 Shaw, Paris 61944
E. T. Leonard
3 Crestwood Ln., Rockford 61107

INTERN AND RESIDENT:
Michael J. Hughey
711 Laurel Ave., Wilmette 60091

CONSULTANTS:
Eli L. Borkon *(Liason to Council of Deans)*
14 Pinewood, Carbondale 62901
Robert T. Fox
2136 Robin Crest Ln., Glenview 60025
William M. Lees
6518 N. Nokomis, Lincolnwood 60646
STAFF: Philip G. Thomsen

Responsibilities and Purposes:
The Council on Education and Manpower shall study and evaluate all phases of medical education, including the development of programs by and for ISMS, and review programs for paramedical personnel. It shall carry to the deans of medical schools recommendations from the viewpoint of the practicing physician. It shall evaluate available postgraduate programs, advise the Illinois Dept. of R&E, and review hospital oriented education programs. Liaison shall be maintained with the advisory committee to students and physicians-in-training and with loan programs for medical students. Actiivties regarding physician distribution and retention shall also be within the scope of the Council, as well as medical licensure as it relates to education.

Committees:
Accreditation
Advisory Committee to Medical Students
Advisory Committee to Physicians-in-Training

COMMITTEE ON ACCREDITATION

Council Member:
N. Kenneth Furlong, *Chairman*

Non-Council Members:
George O. Dohrmann
3000 Logan Blvd., Chicago 60647
John H. Huss
315 Schiller St., Elmhurst 60126
Howard L. Lange
211 S. 3rd St., Belleville 62221
Rex O. McMorris
619 N.E. Glen Oak Ave., Peoria 61603

STAFF: Philip G. Thomsen

Responsibilities and Purposes:

To review survey reports of institutions which have applied for accredited status and grant accreditation to promote Continuing Medical Education activities; to provide liaison with the Illinois Council on Continuing Medical Educaton.

ADVISORY COMMITTEE TO MEDICAL STUDENTS

Council Member:
Carl R. Barthelemy, *Chairman*

Non-Council Members:
Richard J. Jones
4920 S. Kenwood Ave., Chicago 60615
Theodore R. Van Dellen
200 E. Chestnut St., Chicago 60611

STUDENT REPRESENTATIVES:
Donald D'Amico *(Illinois)*
6250 N. Magnolia, Chicago 60660
Robert DuBroff *(MECO)*
4800 Lake Park Blvd., Apt. 2211, Chicago 60615
James Goedert *(Loyola)*
1023 Ashland Ave., River Forest 60305
Lawrence Kanter *(Chicago)*
4800 Lake Park Blvd., Chicago 60615
David Rollins *(Chicago Medical School)*
408 N. Taylor St., Apt. 3A, Oak Park 60302
William Yasnoff *(Northwestern)*
1310 Judson Ave., Evanston 60201

STAFF: Perry Smithers

ADVISORY COMMITTEE TO PHYSICIANS-IN-TRAINING

Council Member:
Allison Burdick, Jr., *Chairman*

Non-Council Members:
George Gertz
7531 Stony Island Ave., Chicago 60649
Clyde Phillips
841 E. 63rd St., Chicago 60637
Donald H. Wortmann
1429 Myott Ave., Rockford 61101
Vernon L. Zech
St. Therese Hospital, 2615 W. Washington St., Waukegan 60085

PHYSICIANS-IN-TRAINING:
Edith Hartman
1601 W. Taylor St., Chicago 60612
Michael Hughey
711 Laurel Ave., Wilmette 60091
Gaylord Nordine
6144 N. Keystone Ave., Chicago 60646
K. Thomas Papreck
2205 Lynnhaven, Springfield 62704
Gerald Snyder
Methodist Hospital, Peoria 61603
Paul M. Stromberg
1741 N. Neva, Chicago 60635

STAFF: Perry Smithers

COUNCIL ON ENVIRONMENTAL AND COMMUNITY HEALTH

Julius M. Kowalski, *Chairman*
436 Park Ave., E., Princeton 61356
William W. Curtis
100 W. Miller, Springfield 62702
Thomas H. Davison
17 N. Clinton St., Chicago 60606
Edward A. Galapeaux
4340 W. 95th St., Oak Lawn 60453
Eduard Jung
515 Aberdeen Rd., Frankfort 60423
Daniel J. Pachman
2315 E. 93rd St., Chicago 60617
Charles L. Swarts
715 South Blvd., Oak Park 60302
Richard C. Treanor
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Charles H. Westfall
172 Schiller St., Elmhurst 60126

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1515A W. Walnut, Jacksonville 62650
Henrietta Herbolsheimer
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Warren Young
3450 Haweswood Dr., Crete 60417

PHYSICIAN-IN-TRAINING:
Gaylord Nordine
6144 N. Keystone, Chicago 60646

STUDENT REPRESENTATIVE:
Linda Lee Hughey
711 Laurel Ave., Wilmette 60091

AUXILIARY:
Mrs. Edward Szewczyk (Betty)
17 Oak Knoll, Belleville 62223

STAFF: Larry S. Boress

Responsibilities and Purposes:

The Council on Environmental & Community Health shall cooperate with the Illinois Department of Public Health in specific areas. Its responsibilities shall include the maintenance, protection and improvement of the health of the people of Illinois through organized community efforts.

It shall serve as a source of information on chronic illness and communicable diseases and cooperate with institutions and voluntary health agencies in disseminating such information.

It is responsible for medicine's interest in the relationship of man to his surroundings, particularly air, water and soil pollution; health problems related to population growth, urbanization and technological development bearing on the ecology of man.

The council also shall be concerned with diseases and problems associated with occupational and industrial health, cooperate with the Council on Occupational Health of AMA, Industrial Medical Association and similar state agencies and to recommend to the State of Illinois Workman's Compensation Board medical procedures designed to assist the board in the evaluation of claims.

Committees:

Maternal Welfare
Sports Medicine

COMMITTEE ON MATERNAL WELFARE

DISTRICTS MEMBERS AND ALTERNATES
(alternates in italics)
William W. Curtis, *Chairman*
1. William J. Weigel
57 E. Downer Pl., Aurora 60504
Gerald F. Staub
2400 N. Rockton, Rockford 61103
2. William J. Farley
710 Peoria St., Peru 61354
Donald M. Gallagher
Marshall-Putnam Clinic S.C., Granville 61326
3. Alex Kaz
15400 S. Page, Harvey 60426
Charles F. Kramer
12647 S. Justine St., Calumet Park 60643
4. V. B. Adams
301 E. Jefferson, Macomb 61455
Ralph Gibson
416 St. Mark Ct., Peoria 61603
5. William W. Curtis
100 W. Miller, Springfield 62702
Robert Maletich
1025 S. 7th St., Springfield 62703
6. Richard D. Yoder
601 E. 3rd St., Alton 62002
Donald E. Hardbeck
2856 Beltline, Alton 62002
7. Paul A. Raber
149 W. King St., Decatur 62521
Hubert Magill
1170 E. Riverside, Decatur 62521
8. John C. Mason, Jr.
715 N. Logan, Danville 61832
J. Roger Powell
Carle Clinic, 602 W. University Ave., Urbana 61801
9. William B. Skaggs
203 N. Vine, Harrisburg 62946
M. A. Ramasamy
301 N.W. 11th St., Fairfield 62837
10. Arthur A. Smith
306 E. Eighth St., O'Fallon 62269
Allan G. Bennett
Box #2347, Carbondale 62901
11. John J. McLaughlin
2100 Glenwood Ave., Joliet 60435
Charles P. Westfall
172 Schiller, Elmhurst 60126
STAFF: Larry S. Boress

CONSULTANTS:
Robert R. Hartman
1515A Walnut St., Jacksonville 62650
John Louis
2913 N. Commonwealth, Chicago
Willard C. Scrivner
6600 W. Main St., Ste. #2, Belleville 62223
Augusta Webster
707 N. Fairbanks Ct., Chicago 60611

GOVERNMENTAL AFFAIRS COUNCIL

James M. Laidlaw, *Chairman*
Christie Clinic, 104 W. Clark, Champaign, 61820
Thomas Baffes
Mount Sinai Hospital, 2755 W. 15th, Chicago 60608
Finley W. Brown, Jr.
1445 N. State Parkway, Chicago 60610
George H. Burke
Rock Island Franciscan Hospital, 2701 17th,
Rock Island 61201
David J. Clark
1780 W. Galena, Aurora 60506
Robert E. Gorsich
533 W. North Avenue, Elmhurst 60126
Norman Hugo
1023 Woodland, Barrington 60010
Warren W. Kreft
940 Lee Street, DesPlaines 60016
Paul Mahon
326 N. 7th, Springfield 62701
John W. Ovitz, Jr.
204 W. Elm, Sycamore 60178
Elliott Partridge
1201 Pine, Eldorado 62930

CONSULTANTS:
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2136 Robin Crest, Glenview 60025
William M. Lees
6518 N. Nokomis, Lincolnwood 60646
Willard C. Scrivner
6600 W. Main, Suite 2, Belleville 62223
P. John Seward
1601 Parkview, Rockford 61107
Mrs. Pam Taylor
1607 N. Vermilion, Danville 61832
Warren D. Tuttle
203 N. Vine, Harrisburg 62946

AUXILIARY REPRESENTATIVE:
Mrs. Alton (Sharon) Morris
1616 Leland, Springfield

STAFF: Don Udstuen

Responsibilities and Purposes:

1. Keep the Society and its members aware of all state and federal legislation and laws affecting the health of citizens of Illinois and the practice of medicine in Illinois.
2. Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois.
3. Co-operate with the AMA in similar programs.
4. Develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

Committees:

Eye Health
Public Affairs
Ear, Nose, and Throat

EAR, NOSE, AND THROAT COMMITTEE

Jack D. Clemis, *Chairman*
55 E. Washington, Chicago 60202
Irwin Horwitz
55 E. Washington, Chicago 60202
Burton Soboroff
307 N. Michigan, Chicago 60601
STAFF: Don Udstuen

EYE HEALTH COMMITTEE

Council Member:
Warren W. Kreft, *Chairman*
Non-Council Members:
Frederick Crowley
117 Bellemount Road, Bloomington 61701
Maurice M. Hoeltgen
9401 S. Winchester, Chicago 60620
Paul Hauser
2500 Ridge Ave., Evanston 60201
Frank Snell
334 West Main, Decatur 62522
Robert W. Webb
1312 W. Delmar, Godfrey 62035
STAFF: Don Udstuen

PUBLIC AFFAIRS COMMITTEE

Council Members:
Elliott Partridge, *Chairman*
Finley W. Brown, Jr.
James M. Laidlaw
Paul Mahon

Non-Council Members:
Theodore Bartlett
7447 Pottawatomi Drive, Palos Heights 60463
Louis Dondanville
501-15th Street, Moline 61265
Donald Holder
5670 E. State Street, Rockford 61107
W. F. Jacobs
6525 North Avenue, Oak Park
Earl V. Klaren
158 E. Cook, Libertyville 60048
Paul P. Lorenz
P.O. Box 2347, Carbondale 62901
Thomas P. Meirink
8601 W. Main, Belleville 62223
George T. Mitchell
Cork Medical Center, 410 N. 2nd, Marshall 62441
Tassos Nassos
3929 N. Central, Chicago 60634
Albert W. Ray, Jr.
301 N. Reed, Joliet 60435
A. E. Steer,
1020 E. Lake Shore Drive, Springfield 62707
Ronald E. Sumner
300 East War Memorial Drive, Peoria 61614
George T. Wilkins
3165 Myrtle Avenue, Granite City 62040
STAFF: Bob Kjellander

MEDICAL LEGAL COUNCIL

James Habegger, *Chairman*
32 S. Lincoln, Geneva 60134
Donal D. O'Sullivan
411 W. Dickens, Chicago 60614
William Schwingel *(Arbitration)*
1240 N. Highland Ave., Aurora 60506
Marshal B. Segal
2112 N. Dayton, Chicago 60614

Eli Tobias
1330 Braeburn Rd., Flossmoor 60422
Constantine Veremakis
409 E. Park Dr., Belleville 62223
Eugene Vickery
202 S. Schuyler, Lena 61048
Victor Aydt *(Laboratory Services)*
Paris Community Hospital, Paris 61944
Walter Whisler
1211 Chestnut Ave., Wilmette 60091
Charles Wells
117 N. 10th St., Mt. Vernon 62864

CONSULTANTS:
Jacob E. Reisch
1129 S. Second St., Springfield 62704
Herman Wing
400 E. Randolph, Chicago 60601
James Fletcher, Esq.
c/o Burditt and Calkins,
135 S. LaSalle St., Chicago 60603

STUDENT REPRESENTATIVE:
David Hopp
5715 S. Drexel, Chicago 60637

PHYSICIAN-IN-TRAINING REPRESENTATIVE:
Marc Rose
7401 N. Kostner, Skokie 60076

STAFF: Richard A. Ott

Responsibilities and Purposes:

The Medical Legal Council shall cooperate with all organizations interested in medico-legal problems in order to educate members of the profession in medico-legal affairs.

This council shall maintain liaison with the Illinois Bar Association and cooperate with the judiciary in both federal and state courts within the state of Illinois. It shall, when requested by the court, activate the Impartial Medical Testimony panel. The stated objective of the panel is to provide consultations, judgment and opinions in situations in which there is unusual controversy or wide divergence of medical opinion.

The council shall study recommendations of its committees for methods of elevating and maintaining the standards of medical laboratories in Illinois and review developments of possible alternatives to litigation in claims of professional liability. In addition, the council shall be concerned with standards of practice and quackery.

Committees:
Arbitration
Impartial Medical Testimony
Laboratory Services

COMMITTEE ON ARBITRATION

Council Member:
William Schwingel, *Chairman*

Non-Council Members:
Clinton Compere
233 E. Erie, Chicago 60611
David T. Petty
316 N. Michigan, Chicago 60601
Eugene H. Siegal
104 Haven Rd., Elmhurst 60126
STAFF: Richard A. Ott

Responsibilities and Purposes:

The committee shall review alternatives available to the medical profession in amelioration of professional liability litigation; to this end it is engaged in establishing pilot projects for screening panels, arbitration or other activities.

COMMITTEE ON LABORATORY SERVICES

Council Member:
Victor Aydt, *Chairman*

Non-Council Members:
Richard Novak
1601 Parkview, Rockford
Bernard Stodsky
4824 N. Karlov, Chicago
Earl Suckow
617 Glendale, Mt. Prospect 60056
Joseph O. Dean, Jr.
Proctor Hospital, Peoria 61604
Earl Caldwell
2600 S. Michigan, Suite 31, Chicago 60616
STAFF: Richard A. Ott

Responsibilities and Purposes:

The committee shall effect methods of elevating and maintaining the standards of medical laboratories in Illinois, encourage the use of medical diagnostic laboratories supervised by duly qualified physicians and encourage each county and district to establish evaluation committees. It will cooperate with various state agencies in promoting a safe, adequate blood supply for the state.

COUNCIL ON MENTAL HEALTH AND ADDICTION

Patrick Staunton, *Chairman*
540 Linden, Oak Park 60302
J. Richard Gallagher
1330 N. Lake, Aurora 60506
Ronald Shlensky
251 E. Chicago, Suite 930, Chicago 60611
Albert W. Ray, Jr.
(Alcoholism & Drug Dependence)
301 N. Reed, Joliet 60435
Warren R. Dammers
203 N. Vine St., Harrisburg 62946
Glen Tomlinson
4 Lincoln Prof. Bldg., Lincoln 62656
Anthony Busch
4401 Bellevue Place, Belleville 62223
Marvin R. DeHaan
371 Main Place, Carol Stream 60187

Thomas E. Kirts
232 S. 2nd, DeKalb 60115
Geoffrey L. Levy
1100 W. Central, Arlington Heights 60005
Kermit Mehlinger
4901 S. Drexel, Chicago 60615
James Cavanaugh
(IPS Liaison)
1310 Richie, Chicago 60610

CONSULTANTS:
Joseph Skom
707 N. Fairbanks Ct., Chicago
LeRoy Levitt, *Director*
Illinois Dept. of Mental Health
160 N. LaSalle St., Chicago 60601

STUDENT REPRESENTATIVE:
Connie Wehling
2234 N. Seminary, Chicago 60614

PHYSICIAN-IN-TRAINING REPRESENTATIVE:
Edith Hartman
1601 W. Taylor, Chicago

STAFF: Richard A. Ott

Committee:

Alcoholism and Drug Dependence

Responsibilities and Purposes:

This council shall serve as a source of information on mental health matters for ISMS, evaluate information and make recommendations to the Board of Trustees on positions ISMS should take on issues in this area, and cooperate with institutions, voluntary health agencies, state agencies and professional associations in disseminating information on mental health, alcoholism and drug abuse.

The council shall be on the alert for misleading or fallacious programs and information and recommend appropriate action. It shall also be concerned with reviewing legislation related to the field of mental health, alcoholism, drug abuse, and hazardous substances.

COMMITTEE ON ALCOHOLISM AND DRUG DEPENDENCE

Council Member:
Albert W. Ray, Jr., *Chairman*

Non-Council Members:
James West
2800 W. 95th St., Evergreen Pk. 60642
George Stanton
55 E. Washington Blvd., Chicago 60602
Edward Burke
1101 W. Central, Arlington Heights 60005
Douglas Foster
7531 S. Stony Island Ave., Chicago 60649
R. Schuller
Rt. 8, Box 241, 500 W. Court, Kankakee 60901

CONSULTANTS:
Edward Senay, IDAP
1440 S. Indiana, 3rd floor, Chicago 60605
Joseph Skom
707 N. Fairbanks Ct., Chicago 60611
Msgr. Inatius McDermott
126 N. DesPlaines St., Chicago 60606
Paul Buchholz, DDC
300 N. State St., Chicago 60610

STAFF: Richard A. Ott

Responsibilities and Purposes:

The Committee shall work closely with public and private agencies on projects aimed at eliminating the misuse of alcohol and drugs. The committee's functions will include: (1) study, research and dissemination of educational information on drugs and alcohol to members of the medical profession; (2) cooperate in the dissemination of information on the causes, prevention, diagnosis and treatment of alcoholism and drug dependence to the medical profession and to the public; (3) recommend acceptable measures for control of distribution and disposal of drugs and hazardous substances, exclusive of radiation products, and (4) to cooperate with official and non-official agencies in all matters pertaining to this subject.

COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Mack W. Hollowell, *Chairman*
35 Circle Drive, Charleston 61920
Robert Boxer
64 Old Orchard Rd., Skokie 60076
Catherine L. Dobson
5842 S. Stony Island Ave., Chicago 60637
Theodore Grevas
2701 17th St., Rock Island 61201
Robert Hamilton
25 E. Washington St., Chicago 60602
A. J. Kiessel
1800 E. Lake Shore Dr., Decatur 62521
Robert E. McElroy
135 S. Kenilworth, Elmhurst 60126
Alan Taylor
1012 W. Fairchild, Danville 61832

CONSULTANTS:
Robert T. Fox
2136 Robin Crest Ln., Glenview 60025
Robert Hartman
1515A W. Walnut, Jacksonville 62650
Jacob E. Reisch
1129 S. Second St., Springfield 62704

AUXILIARY REPRESENTATIVE
Mrs. Wendall Roller
Box 664, Monmouth 61462

STAFF: Ned Stuppy

Responsibilities and Purposes:

The Council on Public Relations and Membership Services shall plan and execute programs designed to enhance the relationship between the media, clergy, general public and medical profession. Included shall be health education and socio-economic programs believed to be in the best interest of the profession as well as the general public. The council shall be responsible for new member orientation, exhibits and public service programming.

COUNCIL ON SOCIAL AND MEDICAL SERVICES

James C. Reid, *Chairman*
712 S. College, Greenfield 62044
John W. Bowden
330 Madison, Joliet 60435
Audley F. Connor, Jr.
3233 S. King Dr., Chicago 60616
Robert P. Johnson
108 Maple Grove, Springfield 62707
Laurel E. Keith
1725 W. Harrison St., Chicago 60612
Max Klinghoffer
127 E. Vallette, Elmhurst 60126
Shirley A. Roy
5019 N. Sheridan Rd., Chicago 60640
Fred A. Tworoger
4753 Broadway, Chicago 60640

CONSULTANTS:
Henrietta Herbolsheimer
5528 Hyde Park Blvd., Chicago 60637
A. Edward Livingston
326 Fairway Dr., Bloomington 61701

PHYSICIAN-IN-TRAINING:
Paul Stromborg
1741 N. Neva, Chicago 60635

STAFF: Larry S. Boress

Committees:
Aging
Emergency and Disaster Care
Health Care of the Poor and Rural Problems

Responsibilities and Purposes:
The Council on Social and Medical Services shall initiate and implement programs related to health care facilities, hospital services, emergency room and disaster medical care; maintain liaison with the nursing profession and other health-oriented organizations, includng the Illinois Department of Vocational Rehabilitation; handle problems related to aging, rural health and health care of the poor.

COMMITTEE ON AGING

Council Members:
John W. Bowden, *Chairman*
Robert P. Johnson
Shirley A. Roy
Non-Council Members:
Larsandrew Dolan
6016 N. Nina Ave., Chicago 60631
A. Everett Joslyn
557 Keystone Ave., River Forest 60305
Bertram B. Moss
IDPH Hospital, 1919 W. Taylor, Chicago 60612
Stanley R. Palutsis
360 Fairbank Rd., Riverside 60546

CONSULTANTS:
Edward Piszczek
6410 N. Leona Ave., Chicago 60646
Mr. Herman Gruber
AMA, 535 N. Dearborn, Chicago 60610

STAFF: Larry S. Boress

Responsibilities and Purposes:
The Committee is to act as a liaison between the medical profession and the Illinois Department of Aging. It is concerned with the quality of care provided in nursing facilities, and the environment surrounding the non-institutional elderly.

COMMITTEE ON EMERGENCY AND DISASTER CARE

Council Member:
Max Klinghoffer, *Chairman*
Non-Council Members:
Robert F. Bettasso
1703 Polaris Circle, Ottawa 61350
Earl W. Donelan
2425 S. Glenwood Ave., Springfield 62704
James L. Hall
4933 Woodland Ave., Chicago 60615
Lee Johnson
703 N. Easton, Staunton 62088
John W. Otten
416 St. Mark Ct., Peoria 61603
Joseph D. Winterhalter
6106 Abington Dr., Rockford 61109

CONSULTANTS:
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712 N. Bloomington, Streator 61364
Eugene T. Hoban
6429 North Ave., Oak Park 60302
Eugene P. Johnson
P.O. Box 68, Casey 62420

STAFF: Larry S. Boress

Responsibilities and Purposes:
This committee is concerned with improving the delivery of health care in emergency situations. The committee will monitor the effectiveness of emergency medical service programs as they exist throughout the state. It will also assist local and state agencies to evaluate new programs in emergency and disaster health care.

COMMITTEE ON HEALTH CARE OF THE POOR AND RURAL PROBLEMS

Council Member:
Audley F. Connor, Jr., *Chairman*

Non-Council Members:
James S. Berry
1036 W. Stephenson St., Freeport 61032
Helen C. Bonbrest
2045 W. Washington Blvd., Chicago 60612
John L. Froiland
6101 Sheridan Rd. E., Chicago 60660
Eugene Gaertner
318 Madison, Maywood 60153

Alfred D. Klinger
5229 S. Woodlawn, Chicago 60637
Willard C. Scrivner
6600 W. Main St., Ste. #2, Belleville 62223
Lloyd E. Thompson
4601 State St., East St. Louis 62205

CONSULTANTS:
Eugene P. Johnson
P.O. Box 68, Casey 62420
Philip G. Thomsen
13826 Lincoln Ave., Dolton 60419
Mr. David Knoll, SIU
801 N. Rutledge, P.O. Box 3926, Springfield 62708
Mr. Carmelo Rodriguez, ASPIRA
1941 N. Western Ave., Chicago 60647
Mr. Gary B. Schwartz
AMA Health Care of the Poor
535 N. Dearborn St., Chicago 60610

STAFF: Larry S. Boress

Responsibilities and Purposes:

The committee's responsibility is to mobilize and utilize the resources of the medical profession to achieve available and acceptable health care for the poor and for those living in rural areas.

Committees of the Board of Trustees

COMMITTEE ON CONSTITUTION AND BYLAWS

Fred Z. White, *Chairman*
723 N. 2nd St., Chillicothe 61523
Henrietta Herbolsheimer
5528 S. Hyde Park Blvd., Chicago 60637
Eugene P. Johnson
P.O. Box 68, Casey 62420
Warren D. Tuttle
203 N. Vine St., Harrisburg 62946
Herman Wing
400 E. Randolph St., Chicago 60601

CONSULTANT:
James A. McDonald
515 Oakwood Dr., Geneva 60134

Legal Counsel

STAFF: Perry Smithers

Responsibilities and Purposes:

The Committee on Constitution & Bylaws shall:

1) Receive from individual members, county societies, committees, the Board of Trustees and the House of Delegates, all suggestions and proposals for modification of the Constitution & Bylaws;

2) Prepare for the consideration of the House of Delegates, all changes in the Constitution & Bylaws; and

3) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

The Speaker of the House of Delegates shall be an ex-officio member of this committee.

ETHICAL RELATIONS COMMITTEE

Joseph H. Skom, *Chairman*
707 Fairbanks Ct., Chicago 60611
Arthur Goodyear
142 E. Prairie, Decatur 62523
Eugene T. Hoban
6429 North Ave., Oak Park 60302
Ross Hutchison
126 E. 9th St., Gibson City 60936
Frederick E. Weiss
15643 Lincoln, Harvey 60426

STAFF: James Slawny

Responsibilities and Purposes:

The responsibilities and purposes of this committee are outlined in CHAPTER XI. DISCIPLINE, Part 2 *Illinois State Medical Society Procedures.*

Section 1. Illinois State Medical Society Ethical Relations Committee. The Board of Trustees shall appoint from its members an Ethical Relations Committee to review decisions of the component society involving the interpretation of the Principles of Medical Ethics, violations of the Constitution and By-laws of the Illinois State Medical Society or its component societies and charges of misconduct of members of the Society.

Section 2. Appeals from Component Society Verdicts. Appeals received by the Illinois State Medical Society Board of Trustees shall be referred to the Ethical Relations Committee of the Board of review. (Appeals must be accompanied by a comprehensive stenographic record of the proceedings taken before the component county society together with all exhibits submitted in evidence. If the component county society fails to provide the record on appeal, the Ethical Relations Committee of Illinois State Medical Society shall find the accused "not guilty.") The committee shall notify the accused and the secretary of the component society by certified mail at least thirty days prior to the date set for hearing of the appeal. The chairman of the committee shall preside over the hearing in accordance with the rules established by the Board of Trustees.

Section 3. Verdict. The Ethical Relations Committee of the Board of Trustees shall hear any new and pertinent

evidence any interested party desires to present, and at the conclusion of the trial, the decision of the component society shall be affirmed, overruled or sent back to the component society for reconsideration.

Section 4. Notification and right of appeal. The secretary of the Society shall notify the defendant and the secretary of the component society wherein the defendant holds membership, of the action of the Board. In the event of a decision against the accused he shall have the right to appeal the decision to the Judicial Council of the American Medical Association and the secretary of the State Society shall so notify the accused of this right.

EXECUTIVE COMMITTEE

Joseph L. Bordenave, *Chairman*
415 S. 2nd St., Geneva 60134
Eli L. Borkon
14 Pinewood, Carbondale 62901
Robert T. Fox
2136 Robin Crest Lane, Glenview 60025
Fredric D. Lake
999 Michigan Ave., Evanston 60202
J. M. Ingalls
502 Shaw Ave., Paris 61944
Allan L. Goslin
712 N. Bloomington, Streator 61364
Jacob E. Reisch
1129 S. 2nd St., Springfield 62704
William M. Lees
6518 N. Nokomis, Lincolnwood 60646
Joseph H. Skom
707 Fairbanks Ct., Chicago 60611

CONSULTANTS:
James A. McDonald
515 Oakwood Dr., Geneva 60134
E. A. Piszczek
6410 N. Leona, Chicago 60646

STAFF: Roger N. White

Responsibilities and Purposes:

The Executive Committee shall consist of the president, the president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the chairman of the Policy Committee, the secretary-treasurer, the trustee-at-large and the immediate past chairman of the Board provided he is still a Trustee.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy Committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

(Bylaws, Chapter IX, Part 4, Section 2, Paragraph A.)

FINANCE COMMITTEE AND MEDICAL BENEVOLENCE

Robert T. Fox, *Chairman*
2136 Robin Crest, Glenview 60005
Jacob E. Reisch
1129 South 2nd Street, Springfield 62704
Alfred Clementi
675 W. Central Rd., Arlington Heights 60005
Ross N. Hutchison
126 East Ninth St., Gibson City 60936

STAFF:
Roger N. White
Richard D. Hengl

Responsibilities and Purposes:

The Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop a budget for the fiscal year for approval of the Board through the Executive Committee. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

The Finance Committee shall also be responsible for the society's Medical Benevolence Program and shall:

1. Examine applications for financial assistance and determine eligibility.
2. Keep the names of the beneficiaries confidential and known only to the committee.
3. Determine the allotment for each recipient.
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

COMMITTEE ON GOVERNMENTAL HEALTH PROGRAM REIMBURSEMENT

Eugene P. Johnson, *Chairman*
P.O. Box 68, Casey 62420
Julian Buser
6600 W. Main, Belleville 62223
Robert R. Hartman
1515A W. Walnut, Jacksonville 62650
P. John Seward
1601 Parkview, Rockford 61107
Joseph S. Sherrick
903 E. Superior, Chicago 60611
Philip G. Thomsen
13826 Lincoln, Dolton 60419
Frederick E. Weiss
15643 Lincoln, Harvey 60426

CONSULTANT:
Jacob E. Reisch
1129 S. 2nd St., Springfield 62704

STAFF: Alexander R. Lerner

Responsibilities and Purposes:

The responsibilities of the Committee on Governmental Health Program Reimbursement will be to consider all problems of physician reimbursement by the government health programs—Medicare, Medicaid, MEDICHEK and CHAMPUS.

POLICY COMMITTEE

Allan L. Goslin, *Chairman*
712 N. Bloomington, Streator 61364
William M. Lees
6518 N. Nokomis, Lincolnwood 60646
Fred Z. White
723 N. 2nd St., Chillicothe 61523

STAFF: Perry Smithers

Responsibilities and Purposes:

The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

PUBLICATIONS COMMITTEE

Jacob E. Reisch, *Chairman*
1129 S. Second St., Springfield 62704
Warren W. Young
3450 Haweswood Dr., Crete 60417
Eugene T. Hoban
6429 North Ave., Oak Park 60302
A. Edward Livingston
326 Fairway, Dr., Bloomington 61761
George Shropshear
1525 E. 53rd St., Chicago 60615

STAFF: Richard A. Ott

Responsibilities and Purposes:

The Publications Committee shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal* and other Society publications.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal.* It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates and standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the Journal.

The committee may establish such editorial consultation groups as necessary to assist in development of clinical articles and shall authorize all regular and special features.

ADVISORY COMMITTEE TO ISMS AUXILIARY

Fredric D. Lake, *Chairman*
999 Michigan Avenue, Evanston 60202
J. M. Ingalls
502 Shaw Avenue, Paris 61944
Joseph L. Bordenave
415 S. 2nd St., Geneva 60134

STAFF: Roger N. White

Responsibilities and Purposes:

The committee shall consist of the immediate past president as chairman, the president, and the chairman of the Board. The committee shall provide advice and assistance to the president of the ISMS Auxiliary in her program for the year, and shall assist her in interpreting the activities of the state medical society to the auxiliary members.

Direct Reporting Committees

All Board Committees previously noted consist of members of the Board of Trustees. As such they function within the activities of the Board.

Direct Reporting Committees are groups deemed necessary by the Board of Trustees and are created by the Board to meet specific challenges. These committees may function with, and under, a council, or may report directly to the Board of Trustees.

While other select committees will be formed from time to time, at the time of publication the following groups had been established.

COMMITTEE ON COMMITTEES

A. Edward Livingston, *Chairman*
326 Fairway Dr., Bloomington 61701
Eli Borkon
14 Pinewood, Carbondale 62901
Robert T. Fox
2136 Robin Crest, Glenview 60025

STAFF: Perry Smithers

Responsibilities and Purposes:

The Committee on Committees shall consist of three members of the Board appointed by the chairman. It shall serve to review the purposes, activities and structure of any councils or committees at the request of the Board.

The committee shall recommend such changes in existing councils or committees as required to maintain the efficient operation of the affairs of the Society.

The activities and reports of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

COMMITTEE ON COMPREHENSIVE HEALTH PLANNING

John J. Ring, *Chairman*
511 E. Hawley, Mundelein 60060
James B. Borgerson
119 S. Vine St., Mt. Pulaski 62548
Ralph E. Dolkart
707 Fairbanks Ct., Chicago 60611
Robert D. Dooley
6 Oakbrook Club Dr., J-108, Oak Brook 60521
Miller L. Henderson
1215 N. Alpine Rd., Rockford 61107
H. Close Hesseltine
5807 S. Dorchester Ave., Chicago 60637
Charles J. Jannings
301 N.W. 11th, Fairfield 62837
James R. Kennedy
401 N. Wall, Kankakee 60901
Ervin E. Nichols
1 E. Wacker Dr., Suite 2700, Chicago 60601
Irwin A. Smith
1141 Church, Northbrook 60062

CONSULTANTS:
Henrietta Herbolsheimer
5528 Hyde Park Blvd., Chicago 60637
Fred Z. White
723 N. 2nd St., Chillicothe 61523

STAFF: Alexander R. Lerner

Responsibilities and Purposes:

The ISMS CHP Committee has the responsibility of keeping physicians abreast of all developments in the area of health planning and to encourage a leadership role for physicians in this important field. The Committee maintains ongoing liaison with the State CHP Agency and the areawide "b" agencies.

COMMITTEE ON DRUGS AND THERAPEUTICS

Arthur R. Marks, *Chairman*
101 E. Center St., Fairfield 62837
Andrew Krajec
108 W. South St., West Salem 62476
Richard H. Suhs
1409 Stevenson Drive, Springfield 62703
William T. Gogan
7623 W. 63rd St., Summit 60501
Vincent A. Costanzo, Jr.
7531 S. Stony Island, Chicago 60649
Donald Frankel
111 N. Wabash Ave., Chicago 60602

CONSULTANT:
Louis Gdalman, R.Ph.
5418 S. East View Park, Chicago 60615

STAFF: Mrs. Pat Uznanski

Responsibilities and Purposes:

The Committee shall meet periodically to refine the drug list contained in the Drug Manual. It shall work with the Illinois Department of Public Aid in an effort to keep the Drug Manual current and effective. When suggestions and comments from the members are submitted to the committee, it shall review them and present them to the Department of Public Aid when necessary. The committee shall also consider other drug matters affecting the policy of the medical society.

COMMITTEE ON INSURANCE

Phillip D. Boren, *Chairman*
S. Plum, Carmi 62821
Martin Compton
3003 E. Oakland Ave., Bloomington 61701
William A. Henry
2161 Greenbriar, Springfield 62704
Lawrence Knox
1200 N. East St., Olney 62450
B. Franklin Lounsbury
927 Jackson, River Forest 60305
Charles Schlageter
707 N. Fairbanks Ct., Chicago 60611
David S. Fox
826 E. 61st St., Chicago 60637
Donald L. Kessler
8253 N. Keating, Skokie 60076

CONSULTANTS:
Alfred D. Clementi
1320 Haddington, Palatine 60067
A. Everett Joslyn
557 Keystone Ave., River Forest 60305
Jacob E. Reisch
1129 W. 2nd St., Springfield 62704

STAFF: Philip G. Thomsen

Responsibilities and Purposes:

The Committee on Insurance will review society-sponsored insurance programs, which are currently the Tax Qualified Retirement Program (Keogh Plan), Retirement Investment Program, Group Disability Program, Business Overhead Expense Insurance, Group Major Medical Program, Hospital Benefit Program, Group Life Insurance and Professional Liability Insurance Program. The committee will study these plans, make suggestions for changes, additions and cancellation of policies, and investigate other insurance programs that may benefit society members.

NATIONAL LEGISLATION COMMITTEE

Alfred J. Faber
2110 Swainwood, Glenview 60025
Edwin Falloon
9543 S. Central Park, Evergreen Park 60642
Frank J. Jirka, Jr.
1507 Keystone, River Forest 60305
James M. Laidlaw
Christie Clinic, 104 W. Clark, Champaign 61820
Elliott Partridge
1201 Pine, Eldorado 62930

George T. Wilkins
3165 Myrtle Avenue, Granite City 62040

CONSULTANTS:

William M. Lees
6518 N. Nokomis, Lincolnwood 60646

Willard C. Scrivner
6600 W. Main, Suite 2, Belleville 62223

P. John Seward
1601 Parkview, Rockford 61107

STAFF: Don Udstuen

Responsibilities and Purposes:

The National Legislation Committee was formed in 1974 at the request of the Board of Trustees. Its purpose is to study national legislative proposals which have impact on the health care delivery system in Illinois and to promulgate proposals designed to improve the quality of health care and the practice of medicine in Illinois. The Committee will also serve as a source of information to ISMS members on the status of such proposals.

PLANNING AND PRIORITIES COMMITTEE

Joseph H. Skom, *Chairman*
707 Fairbanks Ct., Chicago 60611

Herschel Browns
4600 Ravenswood, Chicago 60640

C. Larkin Flanagan
720 N. Michigan, Chicago 60611

David S. Fox
20829 Greenwood Center Ct., Olympia Fields 60461

Jack L. Gibbs
175 S. Main, Canton 61520

Robert R. Hartman
1515A W. Walnut, Jacksonville 62650

Lawrence L. Hirsch
Chicago Medical School, Downey 60064

Ross N. Hutchison
126 E. 9th St., Gibson City 60936

Richard J. Jones
4820 S. Kenwood, Chicago 60615

B. Franklin Lounsbury
707 N. Fairbanks, Chicago 60615

Jack Means
116 E. Elm St., Mason City 62664

Joseph B. Moles
715 Lake St., Oak Park 60301

James C. Parsons
648 N. Chicago, Geneseo 61254

Alan Spector
2228 W. Estes, Chicago 60645

Ronald T. Staubly, Resident
901 N. First, Springfield 62704

Andrew Thomson
1725 W. Harrison, Chicago 60612

Fred Z. White
723 N. 2nd St., Chillicothe 61523

George T. Wilkins
3165 Myrtle, Granite City 62040

CONSULTANT:

Fredric D. Lake
999 Michigan, Evanston 60202

J. M. Ingalls
502 Shaw, Paris 61944

Responsibilities and Purposes:

The President-Elect shall serve as the Chairman of the Committee on Planning and Priorities. This Committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President.

HOUSE COMMITTEE ON REDISTRICTING

John J. Ring, *Chairman*
511 E. Hawley St., Mundelein 60060

Julian W. Buser
6600 W. Main, Belleville 62223

E. Newton DuPuy
1842 Grove, Quincy 62301

C. Larkin Flanagan
505 N. Lake Shore, Chicago 60611

Jere E. Freidheim
3050 Wallace, Chicago 60616

Aaron B. Gerber
23450 Western, Park Forest 60466

Lawrence L. Hirsch
Chicago Medical School, Downey 60064

Wayne N. Leimbach
1240 N. Highland, Aurora 60506

Eugene T. Leonard
3 Crestwood Lane, Rockford 61107

Warren D. Tuttle
203 N. Vine, Harrisburg 62946

CONSULTANTS:

Fredric D. Lake
999 Michigan, Evanston 60202

J. M. Ingalls
502 Shaw, Paris 61944

Other Appointments and Representatives

REPRESENTATIVES TO STUDENT LOAN FUND BOARD

Donald Stehr, *Chairman*
102 E. Market, Havana 62644

Jack Gibbs
175 S. Main St., Canton 61520

Kimball Ewell
203 N. Vine St., Harrisburg 62946

CONSULTANT:

Jacob E. Reisch
1129 S. 2nd St., Springfield 62704

STAFF: Perry L. Smithers

Purpose:

ISMS representatives on the Student Loan Fund Board are responsible to the Board of Trustees in matters related to administration of the Student Loan Program operated jointly with the Illinois Agricultural Association.

INA-ISMS JOINT PRACTICE COMMITTEE

Bernard H. Adelson
595 Lincoln, Glencoe 60022

Fred Z. White
723 N. 2nd St., Chillicothe 61523

Robert M. Reardon
1008 N. Main St., Bloomington 61701

James E. Coeur
630 Locust, Carthage 62321

STAFF: Philip G. Thomsen II

OTHER REPRESENTATIVES

SWANBERG FOUNDATION, QUINCY
Arkell M. Vaughn
9012 S. Leavitt, Chicago 60620

LONG TERM CARE ADVISORY COUNCIL TO IDPH
Robert P. Johnson
108 Maple Grove, Springfield 62707

MIDWEST REGIONAL LIBRARY ASSOCIATION
Samuel L. Andelman
7842 N. Kedvale, Skokie 60076

LIAISON TO ILL. SOC. OF THE AMER. ASSOC. OF MED. ASSTS.
Carl E. Clark
225 Edward St., Sycamore 60178

ILLINOIS COUNCIL OF HOME HEALTH AGENCIES
Francis Bihss
4601 State, E. St. Louis 62205

CHICAGO ALLIANCE FOR VD AWARENESS
Edward Piszczek
6410 N. Leona, Chicago 60646

BAR ASSOCIATIONS INTERPROFESSIONAL CODE
Donal O'Sullivan
411 W. Dickens, Chicago 60614
Marshall Segal
650 Wrightwood, Chicago 60614

DRUG ABUSE COUNCIL OF ILLINOIS
George Shropshear
1525 E. 53rd St., Chicago 60615
Joseph Skom
707 N. Fairbanks, Chicago 60611

PEDIATRIC COORDINATING COUNCIL
Daniel Pachman
1212 N. Lake Shore, Chicago 60605

JOINT COMMITTEE ON SCHOOL HEALTH
Richard E. Dukes
Carle Clinic, Urbana 61801

ILL. INTERAGENCY COUN. ON SMOKING AND DISEASE
Peter G. Gilbert
116 Sophia St., West Chicago 60185

ILLINOIS MEDICAL RECORDS ASSOC.
David T. Petty
316 N. Michigan, Chicago 60601

IDPH/CHP AD HOC PLANNING COMMITTEE ON PERINATAL MORTALITY
Robert R. Hartman
1515A W. Walnut, Jacksonville 62650
William W. Curtis
100 W. Miller, Springfield 62702

ISMS/IPS PEER REVIEW CONSULTING COMMITTEE
Alex Spadoni, *Chairman*
2301 Glenwood, Joliet 60435
Howard D. Kurland
636 Church St., Evanston 60201
S. Dale Loomis
700 N. Michigan, Chicago 60611
Marshall Falk
4700 N. Clarendon, Chicago 60640
Donovan G. Wright
135 S. Kenilworth, Elmhurst 60126

U.S. PHARMACOPEIA
Joseph Skom
707 N. Fairbanks, Chicago 60611

MD COMMITTEE ON OPTOMETRY
Warren Kreft
940 Lee St., DesPlaines 60016
Samuel Schall
30 N. Michigan, Chicago 60602

SCHOOL HEALTH PHYSICALS TASK FORCE—CHP
Julius Kowalski
436 Park Ave. East, Princeton 61356
Charles J. Jannings, *Alternate*
R.R. #4, Fairfield 62837

STATEWIDE COOPERATING ORGANIZATIONS OF THE COMMISSION ON CHILDREN
Daniel Pachman
1212 N. Lake Shore, Chicago 60605

THE COUNCIL OF EMERGENCY CARE ORGANIZATIONS
Max Klinghoffer
127 E. Vallette, Elmhurst 60126

ILL. REGIONAL MEDICAL PROGRAM
Joseph R. O'Donnell
444 Park, Glen Ellyn 60137

ILLINOIS INTERAGENCY COUNCIL ON SMOKING AND DISEASE
Peter G. Gilbert
415 S. 2nd St., Geneva 60134

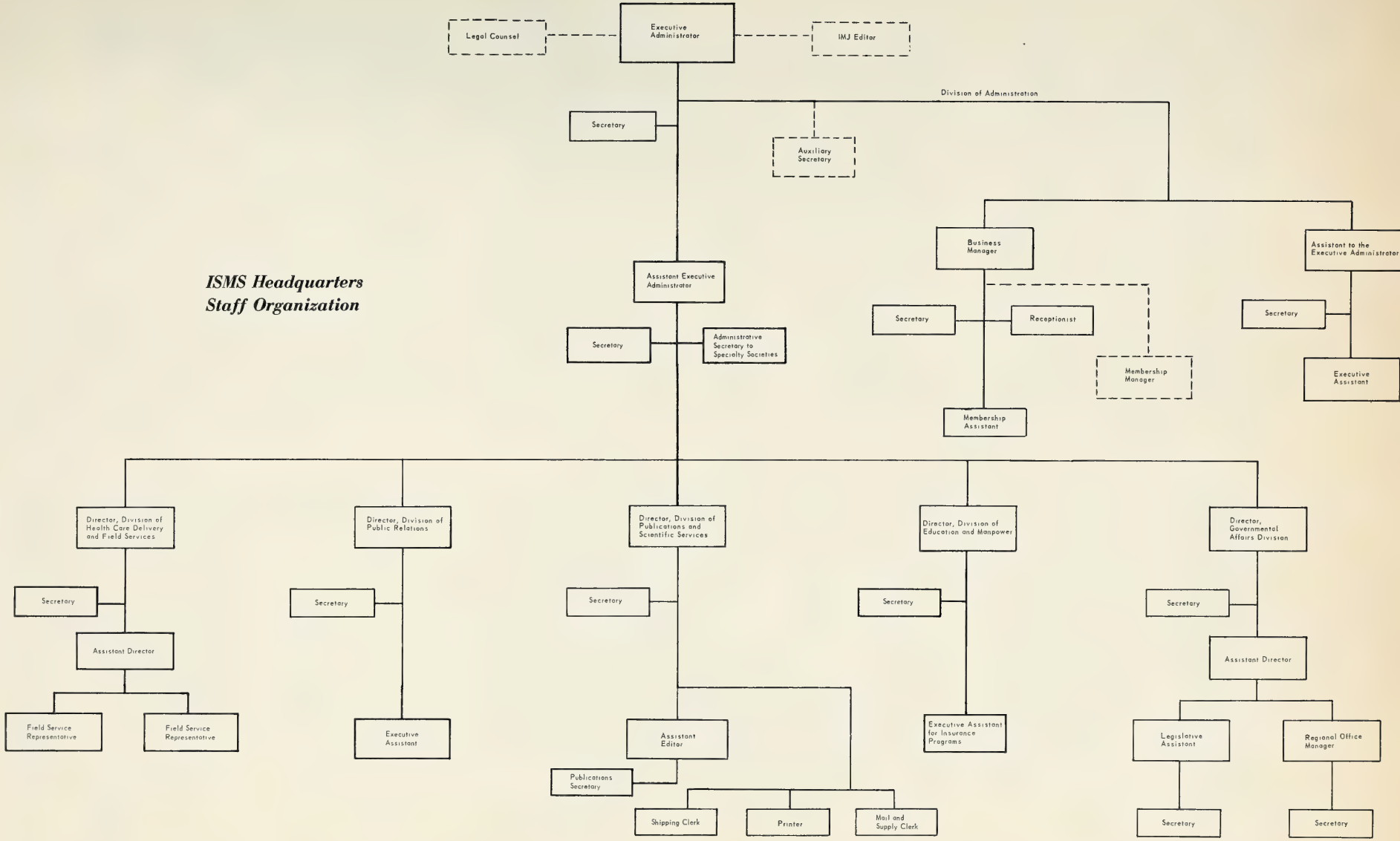
ISMS SERVICES

Pursuit of Obligations

CONSTITUTIONAL PURPOSES OF THE ILLINOIS STATE MEDICAL SOCIETY ARE:

- to promote the science and art of medicine
- to protect the public health
- to evaluate standards of medical education
- to unite the medical profession behind these purposes
- to unite with similar organizations in other states and territories of the United States to

ISMS Headquarters Staff Organization



form the American Medical Association.

The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

To fulfill these purposes, the Society maintains a headquarters office at 55 East Monroe St., Suite 3510, Chicago, and an office in Springfield at 520 S. Sixth St. Services of the Society, under the general supervision of Roger N. White, Executive Administrator, are conducted by the following divisions:

Administration; Public Relations and Membership Services; Governmental Affairs; Publications; Education and Manpower; and Health Care Delivery and Field Services.

Many and varied are the activities of the Society in pursuit of its obligations. Some of these activities are major programs of statewide (and sometimes national) interest for all citizens; others are of special interest to doctors; still others are sponsored for specific groups or individuals.

Following are general descriptions of the Society's divisions and the programs, services and publications available directly to Society members or sponsored for their benefit.

DIVISION OF ADMINISTRATION

The Executive Administrator has the responsibility and the authority to provide for the smooth and efficient functioning of the Illinois State Medical Society.

The implementation of established policy, fiscal and budgetary matters, the employment of qualified personnel and the development and maintenance of personnel policies are all part of the Administrator's activities.

He maintains liaison with the Board of Trustees and assists the chairman in carrying out his duties. Close cooperation with the Speaker of the House of Delegates and the officers of the Society provides a smooth and efficient atmosphere in which the Society may function. Cooperation is maintained with the Committee on Constitution and Bylaws to present to the House all suggested changes for official action. The Administrator channels all legal inquiries and works with the General Legal Counsel to provide guidance to the officers, trustees, committee chairmen and county medical society officers.

To provide the membership of the Society with the best professional staff services available, headquarters has been set up by divisions.

The Assistant Executive Administrator serves within this Division as a coordinator for the programs operated by other Divisions. Further coordination between the programs of the State Society and the County Medical Societies is achieved through Field Services Representatives.

The benevolence programs, travel tours for members, physician placement programs, student loan fund program and all activities concerning the annual meeting are handled within the Division by the Assistant to the Executive Administrator.

The accounting and business service functions of the Society are handled by the Business Manager as a part of this Division. The Division also maintains the membership records and provides a computerized central dues billing and collection center for county medical societies. The Society's accounting and membership records are handled in close coordination with the Secretary-Treasurer under policies laid down by the Finance Committee and the Board of Trustees.

DIVISION OF EDUCATION AND MANPOWER

The Division of Education and Manpower was established in response to the growing demands created by the rapid changes in the education and utilization of physicians and other health care personnel. A primary responsibility of the Division is to maintain information on the changes in medical education. The Division works in consort wth the AMA in keeping abreast of changes in medical school curriculae, and in postgraduate medical education.

In addition, the Division attempts to maintain current information on the training and use of such ancillary personnel as nurse practitioners and physician's assistants. New and innovative use of personnel are studied and recommendations made to the ISMS Board of Trustees as to their appropriateness and legality. All information maintained by the Division is, of course, available to all ISMS members.

The Division is responsible for matters of medical licensure other than illegal practice, and maintains liaison with the Department of Registration and Education to ensure that any licensure problems may be handled expeditiously.

A second major responsibility of the Division is the administration of Insurance Programs sponsored by the Illinois State Medical Society. Included in these programs are the Professional Liability Program, a Major Medical and Excess Limits Major Medical programs, Group Life, Disability and Hospital Benefits Programs. The Division oversees the day to day operation of the programs, including the enrollment of new physicians. In addition the Division receives regular reports on the programs outlining such information as the number of physicians enrolled in the program, amount of premium paid, amounts or money disbursed in claims settlements, etc.

The Division is responsible for the staffing of the Council on Education and Manpower, CME Accreditation, Joint Practice Committee and Insurance Committee.

GOVERNMENTAL AFFAIRS DIVISION

As professional medicine strives to maintain the vigorous condition of the public health, the profession is vitally and intimately concerned with legislative actions of the Illinois General Assembly and the U. S. Congress

which affect physicians, other members of the healing arts, and the lay public. To insure that the best health interests of the public and professional interests of the physician are served, the Division monitors all state and national legislation which affect the health of the individual and his community.

The monitoring process is designed to present the thoughtful views of professional medicine in Illinois on specific medically related pieces of legislation.

The ISMS Governmental Affairs Council acts as the clearing house for legislative proposals recommended by specialized ISMS committees; generated by allied groups; produced by special interests and introduced by representatives and senators. Such legislation is thoroughly analyzed by physician-members of the specialized ISMS committee covering the subject matter of the introduced legislation.

Support or Oppose Legislation

Upon appropriate consideration and recommendation, legislation of medical significance in the Illinois Legislature is either supported or opposed to protect and promote the interests of the public and the profession. Pertinent subject matter testimony is presented before the House and Senate committees as the bill proceeds through the legislative process.

On-the-scene surveillance of monitored legislation is maintained by ISMS legislative representatives.

Through these essential actions, ISMS plays a meaningful role in shaping legislation for the betterment of the people of Illinois.

Action similar to the above is taken with respect to bills in Congress when they have special significance to Illinois physicians. This activity is conducted in concert with the American Medical Association.

Integrated with and designed to augment the legislative activity is the Public Affairs Program. The ISMS Public Affairs Committee strives to alert the physician to his role in public affairs and to involve him in effective participation in public affairs in his community, state, and nation.

Other Activities

The division also staffs the committees on Public Affairs and Eye Health.

DIVISION OF HEALTH CARE DELIVERY AND FIELD SERVICES

Health Care Delivery

The Division of Health Care Delivery and Field Services has the responsibility of keeping ISMS members abreast of the socio-economic issues that have such an impact on the delivery of health care.

The division has expanded its activities in researching the many new types of health care programs being proposed or in varying stages of development throughout the state. Such pertinent socio-economic information will be disseminated to ISMS members through articles in the *Illinois Medical Journal* and "Action Report" and through special programs. The division also works with the Illinois Foundation for Medical Care.

The division staffs the Council on Economics and Peer Review and its committees on Peer Review Appeals and Relative Value Study. Principal duties of the council concern relations with the health insurance industry, government health programs, Comprehensive Health Planning agencies and regional medical programs. The Peer Review Appeals Committee serves as the appellate body for all disputed cases initially considered by local or district peer review committees. The Relative Value Study Committee's task is to develop an Illinois relative value study.

The division staffs the Council on Social and Medical Services. This council initiates and implements programs related to health care facilities, hospital services and emergency room and disaster medical care. It also maintains liaison with other health related organizations such as vocational rehabilitation, aging, health care of the poor, and rural health. Committees of the Council on Social and Medical Services include: Health Care of the Poor and Rural Problems, Emergency and Disaster Care and Committee on Aging.

The division is responsible for staffing the Council on Environmental and Community Health and its Committee on Maternal Welfare and Committee on Sports Medicine. Liaison is maintained with the Illinois Department of Public Health and problems of the membership are relayed to the Department. In addition, ISMS services are coordinated with the Department whenever these are in a joint field of venture. Immunization programs, maternal welfare programs, and screening programs for hypertension and other physical problems are examples of the areas of cooperation between ISMS and IDPH.

The division also staffs the Council on Affiliate Societies in order to enhance communications and provide liaison with the specialty societies.

In addition, the division staffs the Committee on Governmental Health Program Reimbursement that serves as liaison to Medicare, Medicaid, MEDICHEK and CHAMPUS in any matters regarding physician reimbursement by these programs; and the Comprehensive Health Planning Committee that serves as liaison to the Comprehensive State Health Planning Agency and the areawide "b" agencies.

The Division of Health Care Delivery and Field Services attends the Illinois Department of Public Aid's Medical Advisory Committee as an observer, attends meetings of the Illinois Health Facilities Board, the State Council on Aging, Emergency Medical Services Committees and legislative hearings.

Field Services

The primary responsibility of Field Services is to provide liaison, service and education to the society's membership through Field Service representatives. Each field representative has the responsibility for *liaison* with component societies, allied professions and government agencies, to insure state society representation and to provide a means for communication; *service* to the trustees, officers, executives, general membership and county medical societies to provide a constant update on ISMS information, programs and resources, and *education* to the general membership through the distribution of a wide variety of issues affecting the practice of medicine.

DIVISION OF PUBLIC RELATIONS AND MEMBERSHIP SERVICES

The Division of Public Relations functions both as an outlet to the news media and as a source of information for the membership.

Staff members prepare speeches, slide presentations, pamphlets and other materials on a wide range of topics to support activities of officers, councils and committees. In addition, the Division arranges press conferences and prepares news releases to publicize ISMS actions and views on major issues. Also, the Division serves as liaison to the news media, responding to almost daily requests for background information or summaries of society activities.

Beyond these traditional public relations duties, the Division conducts a number of special, highly successful projects. Among them are:

President's Tour . . . takes the ISMS President to each Trustee District and provides an opportunity for members to discuss with the president matters affecting medicine and the society. An integral part of the "tour" is press conferences and media interviews as well as civic club speaking engagements.

Journalism Awards . . . presented annually for "distinguished achievement in medical journalism" in a variety of categories covering all media. The audio-visual presentation ceremony is held during the annual meeting of the House of Delegates. Purpose of the awards program is to strengthen relationship with the media.

Action Report . . . is a bi-weekly newsletter which reports on ISMS activities and major events affecting medicine.

Malpractice Report . . . is a periodic newsletter designed to inform all Illinois physicians, dentists and hospital administrators of the latest malpractice developments and activities of the Task Force on Professional Liability.

AID (Athletics . . . Injury and Disease) . . . assists coaches and trainers in prevention, recognition and initial treatment of injuries and illnesses. This quarterly sports-medicine newsletter is distributed to approximately 2,000 junior and senior high school coaches and trainers in Illinois.

Legislative Radio-TV Activities . . . include programs throughout the state featuring a discussion by a physician and legislator of major health legislation pending in the General Assembly.

Radio-TV Speaker's Bureau . . . provides physicians to discuss general medical topics on regularly-scheduled programs. In addition, the bureau provides physician speakers for civic, fraternal, church and community groups.

Public Service Radio Announcements . . . providing general health information are distributed to more than 150 Illinois radio stations.

Member's Handbook . . . explains ISMS services and membership benefits and is distributed to all new members. Contents are continually updated to provide the latest information about the society.

DIVISION OF PUBLICATIONS, MEDICAL-LEGAL, AND MENTAL HEALTH SERVICES

The Division of Publications, Medical-Legal and Mental Health Services is charged with staff responsibility for activities associated with the Council on Mental Health and Addiction, Medical Legal Council, and the Publications Committee. Under the councils are several committees and sub-committees. In addition, liaison is maintained with many public and voluntary organizations, on a formal basis, in order to keep abreast of current developments and to ensure representation of the Illinois State Medical Society.

Publications

Total production of all printed materials and publications, as well as their distribution, is this division's responsibility, except for distribution of items to selected specific groups. All printing and duplicating services are furnished either through an in-plant shop or outside services through competitive bidding. Modern reproduction and collating equipment allows for professional, commercial-quality production.

In addition, all mail room services are provided by this division. An addressograph and graphotype are utilized as well as a small wing mailer, folder and stuffer, and plate burning cabinet. Mailings are accomplished through computer-supplied labels and the addressograph.

Principal among the publications of the society is the official organ, the *Illinois Medical Journal.* The *Journal* is mailed monthly to all members, as well as other selected individuals, who are urged to read it to keep abreast of the scientific, economic, political, legal and social developments within the state, as such pertain to the practice of medicine. The editor welcomes suggestions for articles which may be of special interest to the membership. All members should consider the *IMJ* a means of communicating with fellow Illinois practitioners.

"Action Report" is an in-house publication totally produced in the ISMS print shop. Special publications, brochures, flyers, pamphlets, letters and cards as required by the several ISMS divisions to carry forth their mission, are produced.

Needs of groups affiliated with or ancillary to ISMS, insofar as reproduction or distribution services are concerned, are also handled through the division office.

Advertising

Commercial advertising is carried within the *Illinois Medical Journal.* The maintenance of the records of advertisers, insertion orders, contracts, and direct communication and liaison with advertising agencies and pharmaceutical houses fall within the purview of the division. This furnishes opportunity of presenting a product to members of ISMS through advertising in ISMS publications.

Other Services

Liaison is maintained with many governmental and voluntary agencies to guarantee an awareness of current activities and to have medicine's voice heard. An ongoing scheduling of meetings of committees provides opportunity for addressing many concerns in mental health, addictions, medical-legal, and laboratory services. The division, in addition, attempts to have expert information available to the members.

SPECIAL PUBLICATIONS

Action Report

"Action Report" is a bi-weekly newsletter published by the Illinois State Medical Society. It is distributed to members upon request. Purpose of the report is to alert physicians to important events or activities affecting the practice of medicine.

A short deadline ensures that important news is disseminated to the physicians as quickly as possible so that appropriate responses may be made.

On the Legislative Scene

Emanating from the Springfield Regional Office is a weekly newsletter, "On the Legislative Scene," published during the weeks the General Assembly is in session.

This is produced by the Governmental Affairs Division and distributed upon request. It includes up-to-the-minute status reports on pending legislation of vital concern to medicine in Illinois. This well-received periodical has permitted immediate response by ISMS representatives in Springfield to specific bills and has alerted physicians to the need for involvement in public affairs.

Oral Contraceptive Forms

Legal consent forms for use when dispensing birth control pills are available to ISMS members. ISMS Trustees asked that the forms be prepared and made available because of adverse court decisions against physicians prescribing the pill.

Use of the consent forms is optional with each physician.

Medical Career Recruitment Programs

The Auxiliary of the ISMS has been a spearhead force in Illinois to interest and recruit the youth of the state in medical careers. Members are asked to aid this effort by investigating the possibility of conducting or participating in career days in their home communities.

A paperback book entitled "Horizons Unlimited" is available from the American Medical Association.

SCIENTIFIC SPEAKERS BUREAU

The Illinois State Medical Society, through its Scientific Speakers Bureau, aids county societies in their efforts to keep members abreast of medical advances by conducting postgraduate medical education programs in their own areas. This assistance includes obtaining speakers, preparing and mailing notices of meetings, and paying an honorarium and travel expenses. ISMS can also provide publicity services upon request.

It also pays a $50 honorarium and expenses for individual speakers obtained by county medical societies for their regular meetings.

The Bureau operates under a grant from Merck, Sharpe & Dohme, which provides funds to the ISMS Educational and Scientific Foundation for the specific purpose of obtaining speakers for county medical society meetings.

The following procedures govern use of the Bureau:

1) County societies select speakers from a roster containing the names of more than 400 speakers and over 1,000 topics.

2) Eight weeks advance notice is required for postgraduate meetings. Requests for such meetings, which usually are scheduled for an entire afternoon, should be sent to the Scientific Speakers Bureau, Illinois State Medical Society, 55 E. Monroe, Chicago.

3) Publicity to media in the area of the meeting will be handled by ISMS upon request of the county society.

4) Postcard notices will be mailed to physicians in the county if requested. ISMS will prepare and mail notices if the information is received no less than three weeks prior to the meeting.

5) The county medical society program chairman and the speaker are both expected to submit to ISMS a report on the meeting and the arrangements.

PHYSICIAN RECRUITMENT & STUDENT LOAN FUND PROGRAMS

The Illinois State Medical Society not only offers help to students who wish to become physicians, but also is able to assist the careers of those already licensed to practice medicine.

The society provides this aid through two special activities. First is its own Physician Recruitment Program & Doctor's Job Fair. Second is the Illinois Medical Student Loan Fund Program that the society sponsors in conjunction with the Illinois Agricultural Association.

PHYSICIAN RECRUITMENT PROGRAM

The Physician Recruitment Program is designed to help physicians find a desirable area in which to establish practice or to relocate. The program's purpose is twofold, since it is interested also in helping those communities which demonstrate need of a resident physician.

More than 600 medical doctors have been placed through this program since its inception shortly after World War II.

The Physician Recruitment Program maintains an up-to-date listing of some 125 "open" areas needing physicians.

This service accepts requests from both physicians and communities for satisfactory placement. In addition, physicians are referred to the service by a number of organizations, among them the American Medical Association, the Illinois Department of Public Health and the Illinois Agricultural Association. Frequently, responsible citizens or overburdened physicians in a community will contact the service.

Another important function of the Physician Recruitment Program is to assist small communities in developing programs to attract physicians such as the Doctor's Job Fair.

The Physician Recruitment Program sends a questionnaire to the applicant physician to obtain information on his educational background, his interests and preferences of type of practice. Upon return of the questionnaire, the physician is sent a complete list of openings. Each opening is detailed on its facilities for home life, office space, proximity to hospital facilities and other specifics. The physician is also sent bulletins with information on new locations as they develop.

The Physician Recruitment Program offers its assistance to all qualified physicians who request it. An applicant need not be a member of the state medical society.

ILLINOIS MEDICAL STUDENT LOAN FUND PROGRAM

The Illinois Medical Student Loan Fund Program is designed to help those who have what it takes to become a physician, but lack sufficient financial resources or a recommendation for medical school.

Loans to students in need are provided by a joint contribution from the Illinois State Medical Society and the Illinois Agricultural Association. The program offers loans up to $750 per semester for four years. The total amount of loan funds available varies from year to year, depending on repayments into the revolving fund. The amount of each individual loan is determined by the student's current financial need. Loan installments are made twice a year. A low interest rate is charged semi-annually from the time the loan is received. The borrower also must insure himself for the entire amount of the loan and pay premiums on the policy. Repayment begins January 1 of the fourth year following medical school graduation.

The program also offers assistance to those who may not have financial difficulties, but are denied matriculation into medical school because their college grades or Medical College Admission Test (MCAT) scores are marginal. The board representing the sponsoring organizations of the program can recommend candidates annually to the University of Illinois College of Medicine. After careful screening to determine whether the applicant has the potential to make a good medical student, the board can recommend him for admittance on the basis of its investigation.

In return for this assistance from the Medical Student Loan Fund Program, the applicant must agree to practice medicine in an Illinois town serving a rural population. Minimum practice time is:

(1) Freshman student receiving recommendation—five years of practice.

(2) Freshman student receiving financial assistance for four years—four years of practice.

(3) Upper classman already in medical school—one year of practice for each year that financial aid is taken (one year minimum).

The applicant may select a practice location of his own choice, provided it is in a community that has demonstrated a physician shortage. The choice is subject to approval by the program's board. The purpose of this agreement is to provide family doctors for the rural communities of Illinois.

To be considered for assistance from the Medical Student Loan Fund Program, an applicant must be recommended by the presidents of his home county medical society and farm bureau. Rules of eligibility require that an applicant be a premedical student of at least three years college standing; that he take a medical college admissions test; and that his college grade transcript be submitted with the completed application form. Students applying to this program for a recommendation must complete an official application for admission to the University of Illinois by November 1. Illinois residency is not required.

The board of the Medical Student Loan Fund Program conducts an annual interview meeting for those students who wish to enter medical school the following September. Students qualifying for the interview are notified and invited in mid-November. Those approved for assistance are accepted on a comparative and competitive basis. Information and applications may be obtained from Roy E. Will, Secretary, Medical Student Loan Fund Board, 1701 Towanda Ave., P.O. Box 901, Bloomington, IL 61701.

IMPARTIAL MEDICAL TESTIMONY

The Impartial Medical Testimony program, in which the Illinois State Medical Society participates, is designed to elicit objective medical truth and facilitate the equitable disposition of cases in the courts of Illinois.

As a technique of judicial administration, impartial medical testimony examiners are ordered by the court when there is evidence of a wide divergence of medical opinion in the case which is subject to litigation. The introduction of the IMT examiner and subsequent examination provides the court with objective, impartial medical data for use in pre-trial conferences and in jury trials.

Authorization for the use of IMT examiners was established by the introduction of Illinois Supreme Court Rule 17-2 (subsequently renumbered 215-d) in September, 1961.

The Illinois State Medical Society played a significant role in the creation and development of the IMT program. Impartial medical testimony in other states is limited to certain jurisdictions with-

in the states.

The panel of impartial medical examiners is comprised of approximately 250 physicians who are grouped into medical specialties. Composition of the panel is reviewed periodically to maintain the highest standards for the courts of Illinois.

The Illinois State Medical Society is appreciative of its role in offering, in conjunction with the Supreme Court, impartial testimony for the courts of Illinois. The Medical-Legal Council of the state society is charged with the responsibility of maintaining the IMT panel of qualified physicians.

INSURANCE PROGRAMS

Hospital Income Plan

The Hospital Benefit Plan, approved by the Board of Trustees March 14, 1971, is available exclusively as a benefit to ISMS members. The society derives no income from sponsorship.

The Plan pays $25 in cash (Plan A) or $50 in cash (Plan B) for each day the participant is confined to a hospital because of accident or illness for as long as one full year, up to $9,125 (Plan A) or $18,250 (Plan B) for each accident or sickness.

All active members of the society, their employees and their families are eligible for participation during enrollment periods conducted by the Administrator, Robinson-Kirke Administrative Services, Inc., 209 S. LaSalle St., Chicago 60604.

The daily benefits are automatically doubled for all participants under age 65 for hospital confinement due to cancer or hospital confinement in an intensive care unit.

The plan pays regardless of any other insurance policies members have, and in addition to Medicare and Social Security benefits. Benefits are paid directly to the participant and not to a doctor or hospital. Benefits are not taxable and, therefore need not be included in one's tax return.

The coverage is limited to sickness which commences or accidents which occur while the insurance is in force. However, conditions pre-existing the effective date of insurance will be covered if the participant has not received treatment or medical advice during any period of 12 consecutive months ending after the effective date of insurance. After two years from the effective date of insurance, coverage is guaranteed regardless of any pre-existing conditions.

The plan includes these exclusions: war or act of war, service in the armed forces of any country or international authority at war, pregnancy (including childbirth or resulting complications), or intentionally self inflicted injuries, suicide or attempted suicide, whether sane or insane.

In summary, in 1971 the Hospital Benefit Plan was made available to the membership and was received very well. During enrollment periods all members regardless of age could participate. Enrollment periods are anticipated every 12 to 18 months.

Group Disability Program

The Illinois State Medical Society's officially approved Group Disability Program is available to all eligible members of ISMS up to age 60 who are regularly attending all of the usual duties of their occupation and is renewable to age 70. Three different types of coverage are available under the program, with an over-70 conversion privilege.

Benefits of the program are payable regardless of any other insurance and no restrictive riders may be attached after issuance. The master contract contains a special renewal condition whereby the individual coverage cannot be terminated.

The program is explained in detail in a brochure which is available by writing to Parker, Aleshire & Co., 9933 Lawler Ave., Skokie 60076.

Group Major Medical Expense Plan

A $25,000 Group Major Medical Expense Plan designed for the Illinois State Medical Society has a 20% co-insurance feature and a $500 or $1,000 deductible, whichever the physician selects. For hospital room and board, the Plan will pay up to $100 a day and in addition up to $150 a day in an intensive care unit. It will pay $20 a day in a convalescent home following release from a hospital up to 90 days. The Plan also provides maximum coverage for the insured in the event of mental illness and up to $2,000 for dependents. It will also cover a congenital abnormality from the first day of birth after the effective date of the contract up to $2,000.

New members joining ISMS will be allowed to enroll without evidence of insurability or health statement under age 40 within six months after notification of the Plan's availability.

The Group Major Medical Expense Plan is outstanding and will provide members with protection against catastrophic illness.

The Plan is underwritten by the Commercial Insurance Co. of Newark, N.J., and is administered by Parker, Aleshire & Co., 9933 Lawler Ave., Skokie 60076. Additional information may be obtained from the Illinois State Medical Society headquarters.

Business Overhead Expense Group Plan

Today, more than ever, maintaining a medical office is costly when one considers the increasing cost of rent, employee's salaries, accountant services, utilities, etc. The sole purpose of the Business Overhead Expense Group Plan is to step in and take care of overhead expenses during a period when the physician is totally disabled as a result of an accident or illness. In the event of a serious accident or illness, the physician can keep his office open and retain his personnel with the expenses being taken care of by the Business Overhead Expense Group Plan. This Program is not to be confused with the Group Disability Plan which provides an earned income for physician to meet his personal obligations for the maintenance of his home and family.

Monthly benefits are available up to $2500.00 with attractive premiums. Benefits commence on

the first day provided total disability lasts one (1) month or longer. It will continue while totally disabled for as long as 24 months for any one accident or period of sickness. The premiums for this particular type of coverage constitute business expenses and are deductible under Internal Revenue Service Ruling (55-264, I.R.S. 1955-19, p. 8.).

Further information may be obtained from the administrator, Parker, Aleshire & Co., 9933 Lawler Ave., Skokie, Ill. 60076.

Professional Liability Program

A new professional liability insurance program became available to members of the Illinois State Medical Society June 1, 1973. Underwritten by the Hartford Insurance Group and administered by Johnson and Higgins, Inc., the program requires the active involvement of physicians in claims and underwriting procedures. Through medical review committees operating in each ISMS district, the insurance company receives recommendations on the best course of action to be taken to protect the program and still be responsive to the individual physician's needs.

The program covers physicians and surgeons for alleged malpractice claims arising from professional acts or omissions. Limits of $1 million, $2 million, $5 million or $100,000/$300,000 are available. Corporations and partnerships may be covered for an additional premium if each member is insured for a minimum of $1 million.

Optional personal excess liability protection is also available.

More than 4,000 Illinois doctors are now enrolled in this program and new applications are being received daily at ISMS headquarters. The plan offers these unique features not obtainable elsewhere:

*ISMS members are insured regardless of their specialty, age, experience, location or where they received their medical degrees.

*A network of volunteer medical review committees composed of ISMS members helps obtain coverage for many physicians who otherwise are unable to obtain it or must pay prohibitive premiums.

*If a review committee rules that a physician involved in litigation—even if he loses the case or settles out of court—was practicing according to reasonable standards of care, the Hartford will not cancel his coverage or impose a deductible or surcharge.

*The emergency claim experience of ISMS members monitored through the Johnson and Higgins computer enables the Hartford to adjust territorial and specialty rate classifications to reflect the actual experience of the ISMS group rather than the national or industrial averages.

*ISMS members are assured of a premium structure that is competitive with other programs offered in Illinois.

*The permanence of the program is guaranteed by a progressive enrollment requirement that is currently ahead of schedule and by a contractual provision allowing limited rate increases for the underwriter.

To facilitate premium payments, a standard quarterly billing cycle has been established.

Full details and application forms may be obtained from ISMS or Johnson & Higgins, 101 S. Wacker Dr., Chicago 60604; phone 312-236-3491.

Personal Life Insurance Program

A guaranteed renewable term life insurance program, recommended by the Insurance Committee and approved by the Board of Trustees in 1972, is available to ISMS members in amounts ranging from $10,000 to $200,000. Features of the program include guaranteed future purchase options, guaranteed conversion privilege up to age 70, optional family insurance benefits, double indemnity and disability waiver premium.

For applications and further details, contact the administrator: A. W. Ormiston & Co., 175 W. Jackson Blvd., Chicago 60604; phone 312-922-3952.

ISMS Annual Meeting

April 25-29, 1976

The Palmer House **Chicago**

Ancillary Organizations

Illinois State Medical Society Auxiliary

Patchwork 1975-76

With a summer of planning and scheduling behind us, the Auxiliary is busily stitching together the many and varied patches which will make up the complete design of our year.

The national convention was an exciting time and we were happy to receive recognition for last year's work—now we hope to build from that information to greater heights.

Our representatives to the Indianapolis assembly of "Women United Against Rape" brought back practical ideas for safe-guarding women from violent attack. These ideas and programs will be presented along with many others for improving family safety and health at our Springfield meeting on September 25, 1975. This will be an ideal time to visit the historic Springfield area as well as raise our awareness of Auxiliary plans and practical methods of procedure.

In our district meetings the friendly and dynamic aspects of the over-all Auxiliary purposes will be stressed. We will put into effect our feelings about community good health programs, increasing our membership, strengthening family relationships, benevolent activities, and legislative improvements. We will stress immunization in October. And above all we will emphasize the basic and unifying design of the beautiful patchwork of our Auxiliary quilt: Support of the profession of medicine, especially in its relationship to the communities where we live.

One project which we expect to spread quickly through the state is the printing of posters illustrating the Heimlich maneuver for coping with choking—the so-called "cafe coronary." These posters will be given to restaurants for posting in a prominent place in their kitchens, so their personnel may become familiar with the techniques of helping a victim expel the chunk upon which he is choking. Whenever possible these posters will also be given to schools, police and sheriff's departments and others concerned with rescue work.

Another project, like the preceding one already started in Stephenson County, will be to interest the telephone company in including in its annual directory a page upon which is assembled the listing of all community health and welfare agencies. Many persons, new in a community. do not know where to look for help.

One more prominent patch in our year-long design will be the November Confluence for Health jointly sponsored by ISMS and ISMS Auxiliary. Here we will get together with representatives from other organizations to spark new ideas and plans for health, mental and physical, in all aspects of our lives.

After an active and beneficial year, we will crown our efforts with a patriotic and medically stimulating "Convention 1976".

Let us be active GOODFINDERS!

Mrs. Eugene (Millie) Vickery
President

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3rd Vice-President
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2639 Vermont, Quincy 62301

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Religion and Medicine Mrs. Clement Cunningham
2921 27th St., Rock Island 61201

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349 S. Elmwood Lane, Palatine 60067

ASAMA Mrs. Ralph White
1101 N. Kenilworth Avenue, Oak Park 60302

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BiCentennial Mrs. Thomas Glatter
4729 White Oak Avenue, Rockford 61111

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Mrs. George D. Wardle
800 Geddes Court, Winthrop Harbor 60096

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8. Mrs. Julius Blumenstock
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9. Mrs. Raymond Coss
Route 5, Hawthorne Hills, Mt. Vernon 62864

10. Mrs. H. Frank Holman
302 Paddock Rd., Belleville 62223

11. Mrs. James West
740 Greenview Road, Itasca 61043

American Association of Medical Assistants Illinois Society

Membership in the Illinois Society, American Association of Medical Assistants is open to all persons employed by physicians in administrative and clinical categories. Membership includes medical assistants, office nurses, technicians, secretaries, bookkeepers, clerks and aides. The Society's objectives are to: (a) maintain and advance the standards of professional employment and to give honest, loyal and efficient service to the medical profession and the public; (b) assist the physicians in improving medical public relations; (c) bring into one association all medical assistant organizations of the state of Illinois; (d) provide an organization for those residing in Illinois counties where no medical assistant societies are organized; and (e) meet occasionally for interchange of ideas.

Membership is tri-level, structured similarly to that of the A.M.A.: medical assistants join together to form a county chapter, county chapters form the state society, and state societies form the national organization. There

are active chapters in the following Illinois counties: Cook (Chicago, Cook County South, Aux Plaines, Southwest Suburban, and Northwest Cook), Coles-Cumberland, DuPage, DeKalb, Henry-Stark, Iroquois, Jefferson-Hamilton, Kane, Kankakee, LaSalle, Little Egypt-Williamson, Macon, McDonough, McHenry, McLean, Morgan-Scott, Perry, Peoria, Randolph, Rock Island, Sangamon, Shawnee, St. Clair, Spoon River Valley, Vermillion, and Will-Grundy.

Local county societies and the Illinois Society conduct numerous activities and professional education programs to educate and inform members. Major program at the state level include: (1) "traveling courses' held throughout the state; (2) a symposium each September; (3) area meetings in conjunction with the ISMS President's Tour; (4) a three-day annual meeting in April; (5) publication of a newsletter, "Executive Memo", which keeps members up to date on AAMA activities; and (6) publication of a quarterly journal, *The Illini Cardinal*. Members are also entitled to the bi-monthly professional journal *The Professional Medical Assistant*, group insurance programs, as well as many other benefits through the AAMA. A national convention is held each year which includes programs of an educational nature. Members may also participate in a "home study" continuing education program utilizing audio cassettes and workbooks.

The medical assistant may become a Certified Medical Assistant (CMA) by successfully completing the special board examination and meeting qualifying criteria of the American Association of Medical Assistants certification program. For further information about this program write to the American Association of Medical Assistants, One East Wacker Drive, Suite 1510, Chicago 60601.

Contact the Illinois Society, AAMA President, Mrs. Brown (see below) for membership information.

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4250 Main Street, Skokie 60076
312-677-9016 or 312-286-2166

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333 W. 76th Street, Chicago 60620

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The Educational & Scientific Foundation

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of clinical science through:

1) The initiation of scientific and medical research activities.

2) The collection, evaluation and dissemination of the results of research activities to the public.

3) The implementation and management of projects related to medicine for individuals, or organizations seeking to inform or educate others, or to improve their own knowledge.

The Foundation is a distinct corporate entity which has an interlocking Board with the Illinois State Medical Society. It is staffed through ISMS headquarters.

Board of Directors

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STAFF: Perry Smithers

Illinois Council on Continuing Medical Education

This Council was created by the Illinois State Medical Society, in co-operation with the state's eight medical schools, to fulfill six purposes: (a) make readily available to all Illinois physicians CME programs that will enhance patient care; (b) catalog and co-ordinate existing programs to eliminate wasteful duplication; (c) encourage development of new CME methods, techniques, and systems; (d) help identify the learning needs of Illinois physicians; (e) seek out potential CME providers and serve as liaison between producers and consumers; and (f) encourage Illinois physicians to participate in formal CME programs.

ICCME was proposed by Dr. Edward W. Cannady in his 1969 inaugural address as President of ISMS. Following careful study, the 1970 House of Delegates approved the plan in principle. The next President, Dr. J. Ernest Breed, vigorously pursued the idea; after the 1971 House of Delegates voted initial funding, he also served as Chairman of the Organizing Committee. The Illinois Association of Osteopathic Physicians & Surgeons also offers financial support for ICCME.

ICCME was officially chartered by the state as a non-profit educational organization in May, 1972, and began operations with the appointment of its first Executive Director in September, 1972.

ICCME is unique in three respects: (1) it is the only such organization supported by a state medical society and staffed by a full-time professional educator; (2) it unites the educational resources of the Illinois State Medical Society and the state's medical schools; *and* (3) independent in action, it serves *all* interests concerned with CME and thus provides a crucial channel of communication to co-ordinate the efficient use of all available resources.

Current Major Activities:

1. Sponsor an annual Congress on Continuing Medical Education, to involve all elements of the Illinois health-care system in the Council's work. The third Congress met April 18, 1975. (For a copy of the Congress Report, just write "1975 Congress Report" on your prescription blank, and mail to: ICCME, 55 E. Monroe, Chicago, IL 60603.)
2. On behalf of ISMS, perform staff work for accreditation of intra-state CME.
3. Advise hospitals and other organizations on effective CME methods.
4. Organize training sessions on CME methods for Directors of Medical Education and Program Chairmen.
5. Distribute a pamphlet, *Your Personal Learning Plan,* offering advice on how to plan your learning most effectively. Every Illinois physician—M.D. or D.O.—may receive a copy free upon request; just write "Personal Learning Plan" on your prescription form, and mail to ICCME (*see* address under 1, *above*). To all others, the cost is $1.00/copy, postpaid.
6. Maintain a map of Illinois, plus detailed data, showing distribution of physicians and health institutions pertinent to state-wide CME planning.
7. Maintain and publish a monthly calendar of Illinois CME activities for *IMJ.*

Organization & Governance

Members of the ISMS Executive Committee serve as legal members of the ICCME Corporation, set basic policy, and elect the Board of Directors.

The affairs, property, and business of the Council are managed by a Board of Directors comprised of: eight practicing physicians selected by the ISMS Board of Trustees; eight academic physicians, one selected by each dean of an Illinois medical or osteopathic school; plus the chairman of the ISMS Committee on CME Accreditation.

Board of Directors

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2421 W. Rohmann Ave., Peoria 61604

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Rush-Presbyterian-St. Luke's Medical Center,
1725 W. Harrison St., Room 916, Chicago 60612

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Hines 60141

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U of I College of Medicine,
808 S. Wood St., Chicago 60612

Executive Director: Leonard S. Stein, Ph.D.

Illinois Foundation for Medical Care

The Illinois Foundation for Medical Care is a physician-member, not-for-profit corporation established in July, 1971, at the request of the ISMS House of Delegates. Through the Foundation, physicians retain the prerogatives of medical determinations and have direct participation and leadership in the design, implementation and administration of various health care programs.

A total of ten foundations have affiliated with Illinois FMC: Chicago FMC, Northern Illinois FMC, Quad River FMC, East Central Illinois Foundation for Health Care (previously Champaign County FHC), Western Illinois FMC, FMC of Central Illinois, and Mid-State FMC. This year three new organizations signed affiliation agreements, these were: Southwestern Illinois Medical Review Organization (SWIMRO), Southern Illinois Medical Review Organization (SIMRO), and Crescent Counties Foundation for Medical Care. Now every area in the State has a local foundation or review organization supported by and representative of the physicians in each of the regions in Illinois.

Since its implementation in February, 1972, the Hospital Admission and Surveillance Program (HASP), a program of the Foundation, has certified the medical necessity and length of stay for more than 900,000 Medicaid admissions as of July 1, 1975.

Six of the affiliates have been granted Board approval to administer HASP in their foundation areas. In addition, two of the affiliates, Northern Illinois FMC and Western Illinois FMC, hold commercial contracts to perform HASP-type review for major industries in their areas.

The Foundation is also promoting, cooperatively with the local affiliates and the Illinois Hospital Association and its member hospitals, an all-patient (except for Medicaid patients who are reviewed by HASP) hospital review system—Physician Evaluation Educational Review System (PEERS). PEERS serves as a tool for review committees to evaluate the medical care rendered within their institution against their own established criteria, as well as against regional norms of practice. Since this program's inception in March, 1975, it has generated considerable interest among medical and hospital staffs.

Membership in Illinois FMC is available to any licensed physician or osteopath qualified to practice medicine in all its branches. In affiliated local foundation areas, Illinois FMC membership is contingent upon membership in the local FMC. Information can be obtained by writing IFMC, 55 East Monroe Street, Suite 3510, Chicago 60603.

Board of Directors

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**Member of Executive Committee*

Illinois Medical Political Action Committee (IMPAC)

The Illinois Medical Political Action Committee (IMPAC) is a voluntary, non-profit, unincorporated, permanent membership organization founded in 1960. IMPAC serves as the unified political action arm of Illinois physicians and their wives. It cooperates with others in the healing arts professions. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual partici-

pation in IMPAC is one means by which the individual physician and his wife can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the Illinois General Assembly and in the U. S. Congress. It cooperates, both in election efforts and in membership solicitation activities, with the American Medical Political Action Committee (AMPAC), its counterpart on the national level.

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local physician support committees formed on behalf of candidates in U. S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, Suite 3510, 55 E. Monroe, Chicago 60603.

Medical and Paramedical Education

MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

Chicago Medical School
2020 W. Ogden Ave., Chicago, 60612

Northwestern University Medical School
303 E. Chicago Ave., Chicago, 60611

University of Chicago-Pritzker School of Medicine
950 E. 59th Street, Chicago, 60615

University of Illinois College of Medicine
1853 W. Polk Street, Chicago, 60612
Abraham Lincoln School of Medicine, Chicago
Metropolitan Hospital Group, Chicago
Peoria School of Medicine, Peoria
Rockford School of Medicine, Rockford
School of Associated Medical Sciences, Chicago
School of Basic Medical Sciences, Chicago
School of Basic Medical Sciences, Urbana

Loyola University, Stritch School of Medicine
2160 S. First Ave., Maywood, 60153

Rush Medical College
1725 W. Harrison St., Chicago 60612

Southern Illinois University Medical School
801 N. Rutledge, P.O. 3926, Springfield, 62708

ALLIED MEDICAL EDUCATIONAL PROGRAMS
accredited by the
American Medical Association Council on Medical Education

ACCREDITED EDUCATIONAL PROGRAMS FOR LABORATORY ASSISTANT

CHICAGO—Swedish Covenant Hospital
V. A. West Side Hospital
DANVILLE—St. Elizabeth Hospital
ELGIN—Sherman Hospital
OLNEY—Richland Memorial Hospital
QUINCY—Blessing Hospital
RIVER GROVE—Triton College

ACCREDITED EDUCATIONAL PROGRAMS FOR CYTOTECHNOLOGIST

CHICAGO—Michael Reese Hospital & Medical Center
Mt. Sinai Hospital Medical Center
University of Chicago

ACCREDITED EDUCATIONAL PROGRAMS FOR HISTOLOGIC TECHNICIAN

CHICAGO—St. Joseph Hospital
University of Chicago Hospital & Clinics
Mercy Hospital & Medical Center
Mount Sinai Hospital & Medical Center
Holy Cross Hospital

ACCREDITED EDUCATIONAL PROGRAMS FOR MEDICAL ASSISTANTS

BELLEVILLE—Belleville Area College
CARTHAGE—Robert Morris School

ACCREDITED EDUCATIONAL PROGRAMS FOR MEDICAL LABORATORY TECHNICIAN

BELLEVILLE—Belleville Area College
EAST PEORIA—Illinois Central College

ACCREDITED EDUCATIONAL PROGRAMS FOR MEDICAL RECORD ADMINISTRATORS

CHICAGO—University of Illinois College of Medicine
NORMAL—Illinois State University

ACCREDITED EDUCATIONAL PROGRAMS FOR MEDICAL RECORD TECHNICIAN

EAST PEORIA—Illinois Central College
PALOS HILLS—Moraine Valley Community College
BELLEVILLE—Belleville Area College

ACCREDITED EDUCATIONAL PROGRAMS FOR NUCLEAR MEDICINE TECHNOLOGY

CHICAGO—Northwestern Memorial Hospital
St. Mary of Nazareth Hospital Medical Center
EVANSTON—Evanston Hospital
HINES—V. A. Hospital
RIVER GROVE—Triton College

ACCREDITED EDUCATIONAL PROGRAMS FOR OPERATING ROOM TECHNICIAN

MOLINE—Moline Public Hospital
PALOS HILLS—Moraine Valley Community College
BELLEVILLE—Belleville Area College

ACCREDITED EDUCATIONAL PROGRAMS FOR OCCUPATIONAL THERAPIST

CHICAGO—University of Illinois College of Medicine

ACCREDITED EDUCATIONAL PROGRAMS FOR PHYSICAL THERAPIST

CHICAGO—Northwestern University Medical School
University of Health Science/
Chicago Medical School
University of Illinois College of Medicine

ACCREDITED EDUCATIONAL PROGRAMS FOR MEDICAL TECHNOLOGIST

BELLEVILLE—St. Elizabeth Hospital
BLUE ISLAND—St. Francis Hospital
CHAMPAIGN—Burnham City Hospital
CHICAGO—Augustana Hospital Health Care Center
Grant Hospital of Chicago
Holy Cross Hospital
Illinois Masonic Medical Center
Louis A. Weiss Memorial Hospital
Mercy Hospital & Medical Center
Michael Reese Hospital & Medical Center
Mt. Sinai Hospital Medical Center
Northwestern University Medical School
Rush Medical School
St. Anne's Hospital
St. Anthony Hospital
St. Joseph Hospital
St. Mary of Nazareth Hospital
University of Illinois College of Medicine
V. A. Research Hospital
DANVILLE—Lake View Memorial Hospital
DECATUR—Decatur Memorial Hospital
St. Mary's Hospital
EVANSTON—Evanston Hospital
FREEPORT—Freeport Memorial Hospital
GENEVA—Community Hospital
GREAT LAKES—U.S. Naval Hospital
HINSDALE—Hinsdale Sanitarium & Hospital
JOLIET—Silver Cross Hospital
St. Joseph Hospital
MAYWOOD—Foster G. McGaw Hosp./Loyola University
OAK LAWN—Christ Community Hospital
OAK PARK—West Suburban Hospital Association
PARK RIDGE—Lutheran General Hospital
PEORIA—Method Hospital of Central Illinois
St. Francis Hospital
QUINCY—St. Mary's Hospital
ROCKFORD—Rockford Memorial Hospital
St. Anthony Hospital
Swedish-American Hospital
SPRINGFIELD—St. John's Hospital
Sangamon State University
URBANA—Carle Foundation Hospital
WAUKEGAN—St. Therese's Hospital
WINFIELD—Central DuPage Hospital

ACCREDITED EDUCATIONAL PROGRAMS FOR RADIOLOGIC TECHNOLOGIST

ARLINGTON HTS.—Northwest Community Hospital
AURORA—Copley Memorial Hospital
BELLEVILLE—Belleville Area College
BLOOMINGTON—Bloomington Normal School X-ray Technology
CENTRALIA—St. Mary's Hospital
CHICAGO—Cook County Hospital
DePaul University
Edgewater Hospital
Englewood Hospital
Franklin Boulevard Community Hospital
Henrotin Hospital
Illinois Masonic Medical Center
Louis A. Weiss Memorial Hospital
Malcolm X Community College
Michael Reese Hospital & Medical Center
Mount Sinai Hospital & Medical Center
Northwestern Memorial Hospital
Provident Hospital & Training School
Ravenswood Hospital Medical Center
Roseland Community Hospital
Rush University
St. Anne's Hospital
St. Joseph Hospital
St. Mary of Nazareth Hospital Center
South Chicago Community Hospital
University of Illinois Hospital
Woodlawn Hospital
Wright Junior College
DANVILLE—Lake View Memorial Hospital
DECATUR—Decatur Memorial Hospital
DIXON—Sauk Valley College
EAST PEORIA—Illinois Central College
ELGIN—St. Joseph Hospital
EVANSTON—St. Francis Hospital
GALESBURG—Carl Sandburg College
GLEN ELLYN—College of DuPage
GRAYSLAKE—College of Lake County
HINSDALE—Hinsdale Sanitarium & Hospital

KANKAKEE—Kankakee Community College
KEWANEE—Kewanee Public Hospital
MACOMB—McDonough District Hospital
MALTA—Kishwaukee Junior College
MOLINE—Lutheran Hospital.; Moline Public Hospital
MORTON GROVE—Oakton Community Hospital
OAK PARK—West Suburban Hospital
OLNEY—Richland Memorial Hospital
PALOS HILLS—Moraine Valley Community College
PEORIA—St. Francis Hospital
QUINCY—Blessing Hospital
St. Mary's Hospital
RIVER GROVE—Triton College
ROCKFORD—Rockford Memorial Hospital
Swedish American Hospital
ROCK ISLAND—Rock Island Franciscan Hospital
SOUTH HOLLAND—Thornton Community College
SPRINGFIELD—Lincoln Land Community College
Memorial Medical Center

ACCREDITED EDUCATIONAL PROGRAMS FOR RESPIRATORY THERAPIST

CHICAGO—Cook County Hospital
Central YMCA Community College
Rush University
Northwestern University Medical Center
University of Chicago Hospitals & Clinics
MOLINE—Luthern Hospital
PALOS HILLS—Moraine Valley Community College
RIVER GROVE—Triton College
ROCKFORD—St. Anthony Hospital
SPRINGFIELD—Memorial Medical Center

ACCREDITED EDUCATIONAL PROGRAMS FOR RESPIRATORY THERAPY TECHNICIAN

ROCKFORD—Swedish American Hospital

ACCREDITED EDUCATIONAL PROGRAMS FOR RADIATION THERAPY TECHNOLOGIST

CHICAGO—Rush University
EVANSTON—Evanston Hospital
HINES—V. A. Hospital

ACCREDITED EDUCATIONAL PROGRAMS FOR SPECIALIST IN BLOOD BANK TECHNOLOGY

CHICAGO—Mount Sinai Hospital & Medical Center
SPRINGFIELD—St. John's Hospital
PARK RIDGE—Luthern General Hospital

APPROVED SCHOOLS OF NURSING

Associate Degree Nursing Program

A coeducational nursing program under the auspices of a junior college, two years in length and leading to an Associate Degree in Nursing. The curriculum consists of arts and sciences at the junior college level and nursing theory closely coordinated with nursing practice, under direction and supervision of the college faculty, in community hospitals and health facilities.

Graduates, both men and women, are prepared to give patient-centered care in staff nurse positions in hospitals, nursing homes and similar situations. They are prepared to cooperate and to share responsibility for the patient's welfare with other members of the nursing and health staff, and to develop their own skills through experience as practicing nurses.

General Entrance Requirements:

Good health.
High school graduation: with courses in biological and physical sciences (1-2 units of chemistry recommended) and mathematics (1-2 units recommended).
Qualification for admission to the college and the nursing curriculum.
Cost: tuition in public supported junior colleges is low, in private colleges considerably higher. Add to this: fees, books, uniforms and maintenance.
Living Arrangements: students live at home, in a college dormitory or other approved residence.
Graduate is eligible to take the state examination for licensure as a registered nurse ("R.N.").

Belleville Area College
Department of Nursing
2555 W. Boulevard, Belleville 62221

Black Hawk College
Department of Nursing
6600—34th Avenue
Moline 61265

College of Dupage
Department of Nursing
Lambert Rd. and 22nd
Glen Ellyn 60137

Elgin Community College
Department of Nursing
1700 Spartan Drive
Elgin 60120

Wm. R. Harper College
Department of Nursing
Algonquin & Roselle Road
Palatine 60067

Illinois Central College
Department of Nursing
Box 2400
E. Peoria 61611

Joliet Community College
Department of Nursing
R.R. #3, Houbolt Avenue
Joliet 60436

Illinois Valley College
Department of Nursing
R.R. #1
Oglesby 61348

Kankakee Community College
Department of Nursing
Box 888
Kankakee 60901

Kaskaskia College
Department of Nursing
Shattuc Road
Centralia 62801

Kennedy-King College
Department of Nursing
6800 S. Wentworth
Chicago 60621

Lake County College
Department of Nursing
19351 Washington
Grayslake 60030

Lewis & Clark Community College
Department of Nursing
Godfrey 62035

Lincolnland Community College
Department of Nursing
3865 S. 6th, Frontage Road
Springfield 62703

Malcolm X. College
Department of Nursing
1900 W. Van Buren
Chicago 60612

Mayfair College Nursing Program
4626 N. Knox
Chicago 60630

Morraine Valley Community College
Department of Nursing
10900 S. 88th Avenue
Palos Hills 60465

Morton College
Department of Nursing
2500 S. Austin Blvd.
Cicero 60650

Olive Harvey College
Department of Nursing
10001 S. Woodlawn
Chicago 60628

Olney Central College of Eastern Illinois
Department of Nursing
305 N. West St.
Olney 62450

Parkland College
Department of Nursing
2 Main Street
Champaign 61820

Prairie State College
Department of Nursing
157th and Halsted
Chicago Heights 60411

Rock Valley College
Department of Nursing
Rockford 61101

Carl Sandburg College
Department of Nursing
Box 1407
Galesburg 61401

Sauk Valley College
Department of Nursing
River Campus, R.R. #1
Dixon 61021

State Community College
Department of Nursing
417 Missouri Avenue
East St. Louis 62201

So. Ill. Collegiate Common Market
Associate Degree Nursing Program
908 Wall St.
Carbondale 62901

Southwest Community College
Department of Nursing
7900 S. Pulaski
Chicago 60652

Thornton Community College
Department of Nursing
50 W. 162nd St.
South Holland 60473

Triton College
Department of Nursing
2000 5th Avenue
River Grove 60171

Waubonsee Community College
Department of Nursing
Rt. 47 and Harper Road
Box 508
Sugar Grove 60554

Baccalaureate Degree Nursing Program

Usually a coeducational nursing program under the auspices of a college or university, this is generally four academic or calendar years in length. The curriculum combines general education with nursing education, leading to the Bachelor of Science Degree in Nursing. Liberal education courses, such as arts and sciences, are shared with all college students. University medical centers and other related hospital and community health agencies are utilized for nursing theory and practice.

Graduates, both men and women, are prepared for beginning nursing positions in hospitals, nursing homes and community health services, and for advancement without further formal education to positions such as "nursing team" leader or head nurse. They also have the foundations for continuing personal and professional development and for graduate study and specialization in nursing.

General Entrance Requirements:

Good health.

High school graduation: college preparatory program including biology and physical sciences (1-2 units of chemistry recommended) and mathematics (1-2 units). Two years of a foreign language may be required. Meets college or university admission standard.

Cost: college or university tuition fees for nursing programs are comparable to those for other majors. Range in Illinois is from approximately $1,000 to $7,000 for tuition and fees for total program. Other expenses: books, uniforms, maintenance.

Living Arrangements: students live at home, in a college dormitory or other approved residence.

Graduate is eligible to take state examination for licenture as a registered nurse ("R.N.").

† Bradley University
Department of Nursing
Peoria 61606

Brokaw Collegiate School of Nursing
of Illinois Wesleyan University
Bloomington 61701

Chicago State University
Department of Nursing
95th & King Drive
Chicago 60628

†*M* DePaul University
Department of Nursing
2323 N. Seminary
Chicago 60614

† Elmhurst College
Department of Nursing
Elmhurst 60126

D† Lewis College
School of Nursing
Lockport 60441

†*M* Loyola University
School of Nursing
6525 N. Sheridan
Chicago 60636

† North Park College
Department of Nursing
5125 N. Spaulding
Chicago 60625

†*M* Northern Illinois University
Department of Nursing
DeKalb 60115

† Olivet Nazarene College
Department of Nursing
Kankakee 60901

D†*M* Rush College of Nursing & Allied Health Sciences
1753 W. Congress Parkway
Chicago 60612

†*M* St. Xavier College
School of Nursing
103rd and Central Park
Chicago 60655

†*M* Southern Illinois University
Division of Nursing
Edwardsville 62025

†*M* University of Illinois
College of Nursing
845 S. Damen
Chicago 60612

Illinois Baccalaureate Nursing Programs For Registered Nurse Students Only

M Governors State University
College of Environmental and Allied Sciences
Park Forest South 60466

D Sangamon State University
Department of Nursing
Shepherd Road
Springfield 62703

† *Will admit RN students to generic baccalaureate nursing programs.*
M Offers masters program(s) in nursing
D Developing

Diploma (Hospital) Nursing Program

A nursing program under the auspices of a hospital or independent school of nursing, two to three years in length, and leading to a Diploma in Nursing. A college or university may provide some of the courses. The curriculum consists of theory and practice focused primarily on instruction and related clinical experience in the nursing care of patients in hospitals. Some liberal arts courses may be included.

Graduates, both men and women, have the understanding and skills necessary to organize and implement a plan of nursing that will meet the immediate needs of one or more patients and that will promote the restoration of health. They are also able to plan with associated health personnel for the care of patients, and may be responsible for the direction of other members of the nursing team.

General Entrance Requirements:

Good health.
High school graduation: Usually upper half of class, with courses in biological and physical sciences (1-2 units, one of which should be chemistry) and mathematics (1-2 units).
Satisfactory results on entrance tests and qualification for admission to the school.
Cost: $900 to $3,500; some include full maintenance.
Living Arrangements: Schools have residence facilities; many permit students to live at home if preferred.
Graduate is eligible to take the state examination for licensure as a registered nurse ("R.N.").

Augustana Hospital
427 Dickens
Chicago 60614

Blessing Hospital
1005 Broadway
Quincy 62301

Cook County School of Nursing
1900 W. Polk St.
Chicago 60612

Copley Memorial Hospital
Weston and Lincoln
Aurora 60507

Decatur Memorial Hospital
2300 N. Edward
Decatur 60507

Evangelical School of Nursing
4440 W. 95th St.
Oak Lawn 60453

Evanston Hospital Nursing Program
2351 W. Sherman
Evanston 60201

Freeport Memorial Hospital
1133 W. Stephenson
Freeport 61032

Graham Hospital
210 W. Walnut
Canton 61520

Illinois Masonic Hospital
836 Wellington
Chicago 60657

Lake View Memorial Hospital
812 N. Logan
Danville 61832

Lutheran General Hospital
1700 Western Ave.
Park Ridge 60068

Lutheran Hospital
555—6th Street
Moline 61265

Memorial Hospital
200 Dodge St.
Springfield 62705

Mennonite Hospital
304 W. East Street
Bloomington 61701

Methodist Hospital
221 N.E. Glen Oak
Peoria 61603

Michael Reese Hospital
2816 S. Ellis
Chicago 60616

Moline Public Hospital
635 Tenth Avenue
Moline 61265

Northwestern Memorial Hospital
250 E. Superior
Chicago 60611

Passavant Memorial Hospital
1600 Walnut St.
Jacksonville 62650

Ravenswood Hospital
1931 W. Wilson
Chicago 60640

Rock Island Franciscan Hospital
School of Nursing
767-30th Street
Rock Island 61201

Rockford Memorial Hospital
2400 N. Rockton
Rockford 61103

St. Anne's Hospital
4950 W. Thomas
Chicago 60651

St. Anthony Hospital
5653 E. State
Rockford 61101

St. Francis Hospital
319 Ridge
Evanston 60202

St. Francis Hospital
211 Greenleaf
Peoria 61609

St. John's Hospital
401 N. 9th St.
Springfield 62701

St. Joseph's Hospital
333 N. Madison
Joliet 60435

St. Mary of Nazareth
1127 N. Oakley
Chicago 60622

South Chicago Community Hosiptal
2320 E. 93rd St.
Chicago 60617

Swedish-American Hospital
1316 Charles St.
Rockford 61101

West Suburban Hospital
518 N. Austin Blvd.
Oak Park 60302

Practical Nursing Program

A coeducational nursing program under the auspices of public vocational education systems hospitals or community agencies, usually one year in length. The curriculum includes nursing theory coordinated with nursing practice.

Graduates, both men and women, of programs in practical nursing are prepared for two roles: (1) under the supervision of a professional nurse or physician, they give nursing care to patients in situations relavtively free of scientific complexity; (2) in a close working relationship, they assist the professional nurse in giving care to patients requiring a high degree of nursing skill and judgment.

Entrance Requirements:

Good health.
High school: Two years minimum, graduation desirable. Junior and senior students who are currently enrolled in high school are eligible to enroll in the practical nursing program as part of their credit curriculum.
Satisfactory results on entrance tests.
References and personal interview.
Cost: None under MDTA programs, to approximately $400 plus maintenance.
Living Arrangements: Students usually live at home or in housing approved by school.
Graduate is eligible to take the state examination for licensure as a practical nurse ("L.P.N.").

Black Hawk College
Practical Nursing Program
6600—34th Avenue
Moline 61269

Bloomington School of Practical Nursing
709 S. Clinton
Bloomington 61701

Chicago Public Schools
Practical Nursing Program
1820 W. Grenshaw
Chicago 60612

City College of Chicago
Health Occupations Careers
Practical Nursing Program
721 N. LaSalle
Chicago 60610

Danville School of Practical Nursing
200 E. Main St.
Danville 61832

Decatur School of Practical Nursing
300 E. Eldorado
Decatur 62523

East St. Louis School of Practical Nursing
1024 N. 2nd St.
East St. Louis 62201

F. W. Olin Vocational
School of Practical Nursing
2200 College Ave.
Alton 62002

Lake County College
Practical Nursing Program
19351 Washington
Grayslake 60030

Lake Land College
Practical Nursing Program
Mattoon 61938

Wm. Rainey Harper College
Practical Nursing Program
Algonquin & Roselle Roads
Palatine 60067

Highland College
Practical Nursing Program
511 W. Stephenson
Freeport 61032

Hinsdale Sanitarium & Hospital
Nursing Program
120 N. Oak St.
Hinsdale 60521

Illinois Central College
Department of Nursing
P.O. Box 2400
East Peoria 61611

Jacksonville Board of Education
Practical Nursing Program
504 E. Court
Jacksonville 62650

Joliet Township High School
Practical Nursing Program
201 E. Jefferson
Joliet 60432

Kankakee School of Practical Nursing
Kankakee Community College
P.O. Box 888
Kankakee 60901

Kishwaukee College
Practical Nursing Program
612 Paish
DeKalb 60115

John A. Logan College
Practical Nursing Program
Carterville 62918

Oakton Community College
Practical Nursing Program
7900 N. Nagle
Morton Grove 60053

Parkland College
Practical Nursing Program
2 Main Street
Champaign 61820

Quincy School of Practical Nursing
820 Vermont St.
Quincy 62301

Rend Lake College
Department of Nursing
315 S. Seventh
Ina 62846

Rockford School of Practical Nursing
5125—35th St.
Rockford 61101

St. Frances Cabrini
School of Nursing
811 S. Lytle
Chicago 60607

St. Mary's Hospital
School of Nursing
1015 O'Connor
LaSalle 61301

Carl Sandburg College
Department of Nursing
S. Lake Storey Rd., Box 1407
Galesburg 61401

Sauk Valley College
Department of Nursing
River Campus, Route #1
Dixon 61021

Shawnee Community College
Department of Nursing
Shawnee College Road
Ullin 62992

S. Eastern Ill. College
Department of Nursing
333 W. College St.
Harrisburg 62946

Spoon River College
Practical Nursing Program
102 E. Elm
Canton 61520

Springfield School of Practical Nursing
1101 S. 15th St.
Springfield 62704

Streator School of Practical Nursing
600 N. Jefferson
Streator 61364

Thornton Community College
Department of Nursing
50 W. 162nd St.
South Holland 60473

Triton College
Department of Nursing
2000 N. 5th Avenue
River Grove 60171

Wabash Valley College
Department of Nursing
2200 College Drive
Mt. Carmel 63863

Attend the ISMS

Annual Meeting

April 25-29, 1976

The Palmer House **Chicago**

ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

For representation in the General Assembly, there are 59 Legislative Districts. Each district elects one senator and three representatives. Thus, the Senate has 59 members and the House 177. Under the new constitution, senators are elected for 4 year terms, representatives are elected for 2 year terms.

The General Assembly shall convene each year on the second Wednesday of January. The General Assembly shall be a continuous body during the term for which members of the House of Representatives are elected. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States Constitution, and act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the President of the Senate. To facilitate the handling of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. These committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.

EXECUTIVE BRANCH

The Constitution provides that the Executive Department shall consist of the Governor, Lieutenant Governor, Secretary of State, Comptroller, Treasurer, and Attorney General. These elected officers of the Executive Branch shall hold office for four years, beginning on the second Monday of January after their election and, except in the case of the Lieutenant Governor, until their successors are qualified. They shall be elected at the general election in 1976 and 1978 and every four years thereafter.

LEGISLATIVE BRANCH

Legislative Procedure

Each member of the General Assembly has the power to introduce bills or resolutions. When a bill is introduced it is read at large a first time, ordered printed, and referred to the proper committee for consideration, except that in case of an emergency, a bill may be advanced without reference to committee. If the committee recommends the bill favorably, it is sent to second reading when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading when it is acted upon by the entire membership of the house that is considering it.

Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (89 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference committees may be appointed to work out the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the Governor for his consideration.

If the Governor thinks the bill should become a law, he will sign it. If the Governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Three-fifths of the members elected to each House can override the veto. He can also veto specific items of an appropriation bill and he may reduce an appropriation. The Governor may also return a bill to the Legislature with specific recommendations for change, thereby obviating the need of vetoing the entire bill.

Note

A Legislative Directory containing the names and addresses of all members of the Illinois General Assembly and the Illinois Senators and Representatives in the Congress is available. Requests should be directed to: Illinois State Medical Society, Regional Office, 520 S. Sixth St., Springfield 62701.

STATE OFFICERS

Governor, DANIEL WALKER, Dem., Chicago

Lieutenant Governor, NEIL F. HARTIGAN, Dem., Chicago

Secretary of State, MICHAEL J. HOWLETT, Dem., Chicago

Comptroller, GEORGE W. LINDBERG, Rep., Crystal Lake

Treasurer, ALAN DIXON, Dem., Belleville

Attorney General, WILLIAM J. SCOTT, Rep., Evanston

Clerk of the Supreme Court, JUSTIN TAFT, Rep., Rochester

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Room 1713, 160 N. LaSalle St., Chicago
524 South Second St., Springfield
Mary Lee Leahy, *Director*

Director's Office

Dolores Reid, Deputy Director, Program Services
John Lambert, Deputy Director, Management Services
Neil Matlins, Deputy Director, Planning, Research and Evaluations
Bill Ryan, Deputy Director, Area Operations
Steve Bishop, Administrative Assistant to the Director (Chicago)
Jess McDonald, Administrative Assistant to the Director (Springfield)
Larry Rau, Legislative Liaison
Sharon Garber, Ombudsman (Springfield)
Reginald Patrick, Ombudsman (Chicago)

Office of Community Relations

524 South Second Street, Springfield
Donald H. Schlosser, *Administrator*

Office of Affirmative Action

2020 West Roosevelt Road, Chicago
Rose Geter, *Administrator*

Office of Guardianship

524 South Second Street, Springfield
Richard S. Laymon, *Guardianship Administrator*

Assistant Guardians

Valerie Davis, 950 East 61st St., Chicago
Patricia Everett, 4302 North Main Street, Rockford
William French, 950 East 61st St., Chicago
Phillip Gorman, 4320 West Montrose, Chicago
Judy Gwin, 4500 South Sixth Street Road, Springfield
Gracie A. Herron, 2125 South First Street, Champaign
William King, 5415 North University, Peoria
Margarita Martinez, 1026 South Damen Avenue, Chicago
John O'Donnell, 1439 South Michigan Ave., Chicago
William Perozzi, 210 North Seventh St., East St. Louis
David A. Sattazahn, 2209 West Main Street, Marion
Carolyn W. Schaefer, 524 South Second Street, Springfield
Fred Toole, 48 West Galena Blvd., Aurora

Program Services

Office of Education and Rehabilitation Services

524 South Second Street, Springfield
Lee A. Iverson, *Director*
Everett E. Hamilton, Funded Programs Consultant
Farrell J. Mitchell, Residential Care Consultant
Illinois Braille and Sight Saving School
(Jack Hartong, Supt.) Jacksonville
Illinois Children's Hospital-School
(Paul Kavanaugh, Supt.), 1950 West Roosevelt Rd., Chicago
Illinois School for the Deaf
(Kenneth Mangan, Supt.), Jacksonville
Illinois Soldiers' and Sailors' Children's School
(Andrew Spelios, Supt.), Normal
Illinois Veterans Home
(Melvin Koch, Supt.), Quincy
Illinois Visually Handicapped Institute
(Thomas Murphy, Supt.), 1151 South Wood Street, Chicago
Community Services for the Visually Handicapped
(Peter R. Paul, Supt.), Room 1700, 160 North LaSalle Street, Chicago
Herrick House Children's Center
(Thomas P. Brennan, Administrator), West Bartlett Road, Chicago
Southern Illinois Children's Service Center
(William F. Ayers, Administrator), Hurst
Maryville Children's Center
(James W. DeLeonardis, Administrator), Maryville

Office of Child Development

524 South Second Street, Springfield
Thomas E. Villiger, *Administrator*
2020 West Roosevelt Rd., Chicago
Carlton Williams, *Assistant Administrator*

Program Operations

Area Offices

Aurora, 48 West Galena Blvd.
Champaign, 2125 South First Street
Chicago East, 1439 South Michigan Avenue
Chicago North, 4320 West Montrose
Chicago South, 950 East 61st St.
Chicago West, 1026 South Damen Avenue
Decatur, 125 North Franklin Street
East St. Louis, 1265 North 89th St.
Joliet, 58 North Chicago St.
Marion, 2209 West Main Street
Moline, 2810—41st Street
Ottawa, 424 West Madison Street
Peoria, 5415 North University
Quincy, 410 North Ninth Street
Rockford, 4302 North Main Street
Salem, 205 East Locust Street
Springfield, 4500 South Sixth Street Road

Management Services

Financial Management

524 South Second Street, Springfield
Matthew J. Finnell, Chief

Information Systems

524 South Second Street, Springfield
Mike Timko, Chief

Office of Manpower

524 South Second Street, Springfield
Thomas A. Nickell, Administrative Assistant

Personnel Administration

524 South Second Street, Springfield
John Henkhaus, Chief Personnel Officer

DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

401 S. Spring St., Springfield, 62706
160 N. La Salle St., Chicago, 60601
LeRoy P. Levitt, M.D., *Director*

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Alan E. Grischke, Chief Legal Counsel
William Fitzpatrick, Assistant Chief Legal Counsel
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Meyer Proctor, Chief, Office of Public Information

Management Services Administration
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Labor Relations Office
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Facilities Planning and Operations Office
Joseph L. McGrath, Chief

Operations Evaluation Office
Donald Carney, Chief

Department of Personnel, Mental Health Field Services
John Meyer, Manager

Division of Community Services
Robert Y. Anderson, Deputy Director

Division of Developmental Disabilities
Richard E. Blanton, Ph.D., Deputy Director

Developmental Disabilities Centers

A. L. Bowen Developmental Center, A. J. Schafter, Ph.D., Superintendent, Harrisburg 62946
Dixon Developmental Center, David Edelson, Superintendent, Dixon 61021
William W. Fox Developmental Center, Myron Birky, Superintendent, Dwight 60420
William A. Howe Developmental Center, Arthur Dykstra, Jr., Superintendent, Tinley Park 60477
Kankakee Developmental Center, Ira L. Collins, Superintendent, Kankakee 60901
Lincoln Developmental Center, Paul Klockenga, Superintendent, Lincoln 62656
Elisabeth Luderman Developmental Center, Fred A. McCormack, Superintendent, Park Forest 60466
Warren G. Murray Developmental Center, Walter P. Plassman, M.D., Superintendent, Centralia 62801
Waukegan Developmental Center, Patrick L. Saunders, Superintendent, Waukegan 60085
The Illinois Institute for Developmental Disabilities, Herbert J. Grossman, M.D., Director, 1640 West Roosevelt Road, Chicago 60608

Division of Clinical Services and Programs
Ivan Pavkovic, M.D., Deputy Director
Division of Alcoholism, Mrs. Roalda J. Alderman, Superintendent
Illinois Drug Abuse Program, Edward C. Senay, M.D., Superintendent
Research Program Advisor, Peter Levison, Ph.D.
Training Program Advisor, Matthew D. Parrish, M.D.

Regions and Institutions

1A (ROCKFORD): Donald W. Hart, Administrator, H. Douglas Singer Mental Health Center, 4402 N. Main St., Rockford 61103
H. DOUGLAS SINGER MENTAL HEALTH CENTER: Matthew D. Parrish, M.D., Superintendent, Rockford 61103

1B (PEORIA): James S. Ward, M.D., Administrator, George A. Zeller Mental Health Center, 5407 N. University, Peoria 61614
GEORGE A. ZELLER MENTAL HEALTH CENTER, James S. Ward, M.D., Superintendent, Peoria 61614
EAST MOLINE MENTAL HEALTH CENTER: Konstantin Dimitri, M.D., Superintendent, East Moline 61244
GALESBURG MENTAL HEALTH CENTER: Angelo Zocchi, M.D., Acting Superintendent, Galesburg 61401

2 (CHICAGO): Prakash N. Desai, M.D., Administrator, 160 N. LaSalle St., Chicago 60601
CHICAGO-READ MENTAL HEALTH CENTER: Peter T. Diamond, Ph.D., Superintendent, 6500 W. Irving Park Rd., Chicago 60634
JOHN J. MADDEN MENTAL HEALTH CENTER: Robert deVito, M.D., Superintendent, 1200 S. First Ave., Hines 60141
ELGIN MENTAL HEALTH CENTER: Robert J. Mackie, M.D., Superintendent, Elgin 60120
MANTENO MENTAL HEALTH CENTER: Ella A. Curry, Superintendent, Manteno 60950
TINLEY PARK MENTAL HEALTH CENTER: Jack Saporta, Ph.D., Superintendent, Tinley Park 60477

3A (SPRINGFIELD): William H. Anderson, M.D., Administrator, Andrew McFarland Mental Health Center, 901 Southwind Rd., Springfield 62703
ANDREW McFARLAND MENTAL HEALTH CENTER: Martin Cohen, Ph.D., Superintendent, Springfield 62703
JACKSONVILLE MENTAL HEALTH AND DEVELOPMENTAL HOSPITAL: William K. Murphy, Superintendent, Jacksonville 62650

3B (DECATUR-CHAMPAIGN): Dale L. Kelton, Ph.D., Administrator, 2310 East Mound Rd., Decatur 62526
ADOLF MEYER MENTAL HEALTH CENTER, Dale L. Kelton, Ph.D., Acting Superintendent, 2310 East Mound Rd., Decatur 62526

4 (EAST ST. LOUIS): Ivan Pavkovic, M.D., Administrator, Alton Mental Health Hospital, 4500 College Ave., Alton 62002
ALTON MENTAL HEALTH HOSPITAL, Endrè Komlos, M.D., Medical Director; Joseph Gruber, M.D., Superintendent, Alton 62002
CHESTER MENTAL HEALTH CENTER, Terry B. Brelje, Ph.D., Superintendent, Chester 62233

5 (CARBONDALE): Robert C. Steck, M.D., Administrator, Anna Mental Health and Developmental Hospital, Anna 62906

ILLINOIS MENTAL HEALTH INSTITUTES: Jack Weinberg, M.D., Director, 1601 West Taylor St., Chicago 60612

ILLINOIS STATE PSYCHIATRIC INSTITUTE: Jack Weinberg, M.D., Director, 1601 West Taylor St., Chicago 60612

INSTITUTE FOR JUVENILE RESEARCH: Frank T. Rafferty, M.D., Director, 907 S. Wolcott St., Chicago 60612

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Honorable John L. Lauer, Broadwell
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Nora Pacheco, Chicago
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DANGEROUS DRUGS COMMISSION

The Drug Abuse Office and Treatment Act of 1972 (PL 92-255) made federal funds available to the states for the purpose of combating drug abuse. In order to receive such funds, a state must submit a plan for implementing and evaluating an effective program for drug abuse prevention, treatment, and rehabilitation. Further, a single state agency must be established as the sole agency for the preparation and administration of the plan and allocation of funds.

The Dangerous Drugs Abuse Act, passed by the Illinois legislature in 1967, created the Dangerous Drugs Advisory Council. Pursuant to federal guidelines, the Act was amended in 1974 to establish the Dangerous Drugs Commission, designating it the single state agency to coordi-

nate and administer drug abuse prevention, treatment and rehabilitation programs. The Commission works in cooperation with other state and federal agencies as well as public and private organizations. The Dangerous Drugs Advisory Council makes recommendations and advises the Commission in carrying out the state plan.

As the state planning agency for drug abuse functions, the Dangerous Drugs Commission is delegated the responsibility of developing and implementing an annual comprehensive state plan to reduce drug abuse and establish priorities in administering federal and state funds provided to support drug abuse programs.

In coordinating state and federal funding of drug abuse functions, the Commission is authorized to make grants-in-aid and purchase care agreements with both governmental and private agencies.

The Dangerous Drugs commission also licenses and regulates all drug treatment, education, prevention and rehabilitation programs in the state, except those conducted within a licensed hospital. The Commission sets treatment standards and issues rules and regulations for the operation of drug abuse programs.

Treatment modalities of programs receiving Dangerous Drugs Commission funds include methadone maintenance, both residential and out-patient; drug free residential and out-patient therapy, and hot-line and crisis referral services. In addition to treatment funding, the Dangerous Drugs Commission supports drug counselor training for previously drug dependent clients as well as clinical staff training.

Since reliable and timely data is essential in evaluating the effectiveness of drug abuse treatment and rehabilitation methods, the Information Services Division of the Commission continually collects, analyzses and applies data concerning clinical operations (medical workups, demographics) and regulatory methadone maintenance (counseling, toxicology, prescription dosages.) The division also keeps a weekly statewide log for methadone clinics, a continuing inventory of drug abuse program resources, and a bank of research data on treatment modalities. All information is strictly confidential.

The Toxicology Division of the Dangerous Drugs Commission is the state laboratory facility which provides drug abuse tests to the state's total client population. The lab is subject to the regulations and standards set by the FDA, the National Institute of Drug Abuse and the Commission itself.

The Dangerous Drugs Commission is located at Marina City Office Building, 300 N. State St., Suite 1500, Chicago, 60610. Phone (312) 822-9860.

LeRoy P. Levitt, M.D., *Chairman,* Chicago
Joseph Cronin, Springfield
Bernard B. Brody, Esq., Chicago
Daniel X. Freedman, M.D., Chicago
Harvey W. Johnson, Jr., Springfield
Joyce Lashof, M.D., Chicago
David M. Law, Washington
Mary Lee Leahy, Springfield
Allyn R. Sielaff, Chicago
James L. Trainor, Chicago
Eugene P. Turner, Chicago
Thomas Kirkpatrick, Jr., Exec. Director

Dangerous Drugs Advisory Council
(Being developed)

DEPARTMENT OF PUBLIC AID

316 South 2nd St., Springfield
James Trainor, *Director*

The Illinois Department of Public Aid administers the federally aided public assistance programs: Aid to Families with Dependent Children; Medical Assistance; and provides supplemental financial grants to eligible recipients of the new federal Supplemental Security Income program for needy aged, blind, or disabled persons. In addition, the department allocates state funds to qualified and requesting governmental units for the administration of General Assistance; and in cooperation with the U.S. Department of Agriculture, administers the Food Stamp program.

Administrative Staff

David L. Daniel, *Assistant Director*
Robert G. Wessel, Chief Assistant to the Director
Mr. Norman Ryan, Deputy Director, Division of Financial Management
Mr. Thomas P. Storer, Deputy Director, Division of Medical Programs
Mr. Robert Peloquin, Deputy Director, Division of Administrative & Support Services
Mr. Jesse B. Harris, Deputy Director, Division of Programs & Services

Cook County Regional Offices

North Region (1-Cook County)
Mrs. Vivian Sosin, Regional Director
North Central Region (2-Cook County)
Mr. James Patrick, Regional Director
South Central Region (3-Cook County)
Mrs. Wilda Mooney, Regional Director
South Region (4-Cook County)
Mrs. Edwyna Barnett, Regional Director

Downstate Regional Offices

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Region II (Peoria)
Mr. Walter R. Bradbury, Regional Director
Region III (Springfield)
Miss Leona Franklin, Regional Director
Region IV (Marion)
Mr. Lawrence E. Duff, Regional Director

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Joel Edelman, Crete, *Executive Director*
Senator Daniel Dougherty, Chicago
Senator John B. Roe, Rochelle
Senator Robert T. Lane, Chicago Heights
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Robert C. Muehrcke, M.D., Oak Park
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William R. Dawson, DC, Alton
R. L. Redman, DC, Springfield
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Charles P. Skaggs, R.Ph., Harrisburg

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Bert Cohn, Okawville
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Edward Farmilant, Chicago
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Elmer Johnson, Joliet
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Albert Teaters, Charleston

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Albert J. Freedman, O.D., Rockford
Henry J. Luckhardt, O.D., Westmont
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Eugene Martin, D.P.M., Schaumburg
O. A. Mercado, D.P.M., Chicago
Genelle B. Smith, D.P.M., Belleville
Raymond Turnley, D.P.M., Chicago

DEPARTMENT OF PUBLIC HEALTH

535 West Jefferson St., Springfield 62706
Joyce C. Lashof, M.D., *Director*

Robert S. Gleason, *Legal Advisor*
Fred Uhlig, *Legislative Liaison*

Office of Management Services

Associate Director
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Affirmative Action & Voluntary Resource
Dorothy Friedman

Budget and Fiscal Operation
George Akehurst

Education and Information Vital Records
Stan Miles

Electronic Data Processing
Thomas Stuckey

General Services
Joseph Schweska

Management Audit
Walter DeWeese

Public Health Laboratories
Richard A. Morrissey

State Center For Health Statistics
John Napier

Office of Consumer Health Protection
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Assistant State Sanitary Engineer
Leroy Stratton
Food and Drugs
Dr. Roy Upham
General Sanitation
Robert Wheatley
Milk Control
Harold McAvoy
Radiological Health
Philip Brunner
Swimming Pools and Recreation
Jerry Ackerman

Office of Health Facilities and Quality of Care
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Executive Assistant
James Yuill
Hospital, Laboratories, and Acute Care Facility Regulation
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Federal Program Section
Douglas Wade
Hospital and Ambulatory Surgical Treatment
Center Section
Robert Bilstein
Geriatric and Long Term Care Section
Bertram Moss, M.D.
Clinical Laboratory and Blood Bank Section
David Bogard
Planning and Conformance
George A. Lindsley
Planning and Construction Sec.
Aden H. Clump
Rehabilitation Section
Mary Alyce Anderson

Office of Health Finance and Local Health
Associate Director
Lowell Johnson
Audit Services Rate Review
James Handy
Research & Development
Ramsey Badre

Office of Health Services and Local Health
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Executive Assistant
Shirley Reed
Dental Health
Vacant
Disease Control and Communicable Disease
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Poison Control
Delores Enrietto
Renal Dialysis
Ruth Shriner
Tuberculosis Control
Al Grant
Venereal Disease Control
Robert Griffin
Veterinary Medicine
Russell Martin, D.V.M.
Family Health
James P. Paulissen, M.D.
Maternal & Child Care
James P. Paulissen, M.D.
MEDICHEK
Wesley J. Duiker
WIC
Patricia Fitzgerald
Vision and Hearing
Phil Shattuck
Emergency Medical Services and Highway Safety
Stephen Hessl, M.D.
Hemophilia
Ruth Shriner

Regional Offices

Region 1A	4302 North Main Street, Rockford 61103
Region 1B	5415 North University Ave., Peoria 61614
Region 2A	421 North County Farm Rd., Wheaton 60187
Region 3A	4500 South 6th St. Rd., Springfield 62706
Region 3B	2125 South 1st St., Champaign 61820
Region 4	Cottonwood Road, R.R. 4, Edwardsville 62025
Region 5	Rt. 3—2209 W. Main, Marion 62959

Public Health Laboratories
2121 West Taylor, Chicago, 60612
134 North 9th Street, Springfield 62706
P.O. Box 2467, Carbondale 62901

LOCAL HEALTH DEPARTMENTS

Adams County Health Department
Gene Mann, M.P.H., Public Health Administrator,
333 North Sixth Street, Quincy, 62301

***Bond County Health Department**
Carole Bone, R.N., Acting Administrator
107 W. College, Greenville, 62246

***Calhoun County Health Department**
Mrs. Margaret Hillen, R.N., Acting Administrator
Hardin, 62047

***Christian County Health Department**
Clara J. Beaty, R.N., Acting Administrator
Court House, Taylorville, 62568

Clay County Health Department
Mrs. Patricia L. Borah, R.N., Acting Administrator
104½ West Second Street, Flora, 62839

Cook County Department of Public Health
John B. Hall, M.D., M.P.H., Director
600 W. Jackson Blvd., Chicago, 60606

District Offices:

North—DesPlaines
South—Harvey
Southwest—Oak Lawn
West—Melrose Park

DeKalb County Health Department
Richard B. Morgan, D.V.M., Public Health Administrator
1731 Sycamore Road, DeKalb, 60115

DeWitt-Piatt Bi-County Health Department
Ruth Gregor, R.N., Acting Administrator
122 East Main Street, Clinton, 61727
Piatt County Office:
Court House, Monticello 61856

Douglas County Health Department
Mrs. Evelyn Henderson, R.N., Acting Administrator
County Court House, Tuscola, 61953

DuPage County Health Department
Jack Kelly, Acting Exec. Director
111 N. County Farm Road, Wheaton, 60187

Effingham County Health Department
Ted E. Crump, Public Health Administrator
407 E. Jefferson St., Effingham, 62401

Egyptian Health Department
Allen Kelly B.S., Public Health Administrator
Route 45, Eldorado, 62930
County Offices:
White County—Carmi, 62821
Gallatin County—Court House, Shawneetown, 62984

Franklin-Williamson Bi-County Health Department
Charles W. Elder, D.D.S., Public Health Administrator
217 East Broadway, Johnston City, 62951
Franklin County Office:
226 North Main, Benton, 62812

Fulton County Health Department
A. James Masters, M.P.H., Public Health Administrator
502 North Main, Canton, 61520

Greene County Health Department
Mrs. Barbara Cook, R.N., Acting Administrator
229 North Fifth Street, Carrollton, 62016

Grundy County Health Department
Mrs. Mary C. Reed, R.N., B.S., Public Health Admin.
1340 Edwards Street, Morris, 60540

Henry County Health Department
Grace Van Vooren, R.N., Acting Administrator
Court House Annex, Cambridge, 61238

Iroquois County Health Department
Mrs. Nancy Zumwalt, R.N., Acting Administrator
123 N. Eighth, Watseka, 60970

Jackson County Health Department
John B. Amadio, Ph.D., Public Health Administrator
342A North Street, Murphysboro, 62966

Jasper County Health Department
Mrs. Inez Holiday, Acting Administrator
113 S. Jackson, Newton, 62248

Jersey County Health Department
Mrs. Nola Kramer, R.N., Acting Administrator
301 S. Jefferson, P.O. Box 69, Jerseyville 62052

JoDaviess County Health Department
Ronald F. Neu, M.P.H., Acting Public Health Admin.
311 South Main Street, Galena, 61036

Kendall County Health Department
Ruth Ann Little, R.N., Acting Administrator
105 Fox Road, Yorkville, 60560

Lake County Health Department
Eugene Theios, M.P.H., Acting Director
3010 Grand Avenue, Waukegan, 60085

Lawrence County Health Department
Maxine Jackman, R.N., Public Health Administrator
Court House, Lawrenceville, 62439

Lee County Health Department
E. S. Parmenter, M.D., Health Officer
413 E. First St., Dixon, 61021

Livingston County Health Department
Mrs. Gladys Kohrt, R.N., Acting Administrator
R.R. 4, Convalescent Center Building, Pontiac, 61764

Logan County Health Department
Thomas A. Oas, Acting Public Health Administrator
128 Pine Street, Lincoln, 62656

McDonough County Health Department
Kathleen Markey, R.N., Acting Administrator
525 E. Grant St., Macomb 61455

McHenry County Health Department
Richard A. Wissell, M.P.H., Public Health Administrator
2200 N. Seminary Avenue, Woodstock, 60098

McLean County Health Department
E. E. Diddams, M.S.P.H., Public Health Administrator
401 West Virginia Avenue, Normal, 61761

Macon County Health Department
Robert E. Shrout, M.A., Public Health Administrator
1085 South Main Street, Decatur, 62521

Menard County Health Department
Charles Mertz, Acting Administrator
809 Old Salem Road, Petersburg, 62675

Monroe County Health Department
Mrs. Mary Kruse, R.N., Acting Administrator
224 E. 3rd Street, Waterloo, 62298

Montgomery County Health Department
C. Tom Larson, B.S., M.H.A., Public Health Administrator
200 South Main Street, Hillsboro, 62049

Morgan County Health Department
William D. Meyer, B.S., Public Health Administrator
234½ West State Street, Jacksonville, 62650

Ogle County Health Department
David Stevents, D.V.M., Acting Administrator
106 South Fifth Street, Oregon, 61061

Peoria County Health Department
Harold H. Rohrer, M.D., M.P.H., Director
2114 North Sheridan Road, Peoria, 61604

PIKE COUNTY HEALTH DEPARTMENT
Mrs. Martha Lowry, R.N., Acting Administrator
216 North Monroe, Pittsfield, 62363

QUADRI-COUNTY HEALTH DEPARTMENT
Marvin F. Powers, Medical Director
Golconda, 62938
Massac County Office:
Court House, Metropolis, 62960
Johnson County Office:
Vienna, 62995
Hardin County Office:
Gross Building, Elizabethtown, 62931

RANDOLPH COUNTY HEALTH DEPARTMENT
Bereth Gehlhausen, R.N., Acting Administrator
110 West Jackson Street, Sparta, 62286

*ROCK ISLAND COUNTY HEALTH DEPARTMENT
Fred J. Siebenmann, Jr., B.S., Public Health Admin.
2116 25 Ave., Rock Island, 61201

SHELBY COUNTY HEALTH DEPARTMENT
Ted E. Crump, Public Health Administrator
123 North Broadway, Shelbyville, 62565

STEPHENSON COUNTY HEALTH DEPARTMENT
Arlo J. Anderson, B.S., Public Health Administrator
12 North Galena Avenue, Freeport, 61032

TAZEWELL COUNTY HEALTH DEPARTMENT
Gordon J. Poquette, M.P.H., Public Health Administrator
1505 Valle Vista, Pekin, 61554

TRI-COUNTY HEALTH DEPARTMENT
Marvin F. Powers, Medical Director
529 Cross Street, Cairo, 62914
Union County Office:
Jonesboro, 62952

VERMILION COUNTY HEALTH DEPARTMENT
William A. Pogsley, Public Health Administrator
808 North Logan, Danville, 61832

WABASH COUNTY HEALTH DEPARTMENT
Mrs. Dorothy Munro, R.N., Acting Administrator
Court House, Mt. Carmel, 62862

WHITESIDE COUNTY HEALTH DEPARTMENT
Janet Blaufuss, R.N., and James Arduini,
Acting Administrators
201 West First Street, Rock Falls, 61071

WILL COUNTY HEALTH DEPARTMENT
James C. Barringer, B.S., Public Health Adm.
501 Ella Avenue, Joliet, 60433

WINNEBAGO COUNTY DEPARTMENT OF PUBLIC HEALTH
Joseph Orthoefer, D.V.M., P. H. Administrator
401 Division St., Rockford, 61108

Others

Berwyn Health Department
J. V. Pelech, M.D., Health Director
6600 West 26th Street, Berwyn, 60402

**Champaign-Urbana Public Health District
Gale Fella, M.P.H., Public Health Administrator
505 South Fifth Street, Champaign, 61820

Chicago Board of Health
Murray C. Brown, M.D., Commissioner of Health
Chicago Civic Center, Room 219, Chicago, 60602

**East Side Health District
Mani K. Sashankar, M.D., Dr.P.H., Public Health Director
638 North 20th Street, East St. Louis, 62205

Evanston-North Shore Health Department
William J. Hixon, Acting Public Health Director
1806 Maple Avenue, Evanston, 60201

Hygienic Institute
Arlington Ailes, M.P.H., Public Health Admin.
LaSalle, 61301

Oak Park Department of Public Health
Lee A. Ellis, Village Manager, Acting Public Health Adm.
1 Village Hall Plaza, Oak Park 60303

Skokie Health Department
Samuel L. Adelman, M.D., M.P.H., Director of Health
8031 Floral Street, Skokie, 60076

**Stickney Township Public Health District
Kenneth Rehnquist, Acting Public Health Director
5635 State Road, Burbank, P.O. 60459

**Limited Services*
***Organized under the Coleman Act*

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***(no one officially assigned to replace Joseph D. Patton, Springfield)*

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(Allied with Public Health Operations)

Committee for Revision of the Rules and Regulations for the Control of Communicable Diseases
Byron J. Francis, M.D., Springfield, *Chairman*
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Helen Bruening, R.N., Springfield
Richard A. Morrissey, Chicago
James P. Paulissen, M.D., Springfield
Olga Brolnitsky, M.D., Chicago
Hugh Rohrer, M.D., Peoria
Stuart Levin, M.D., Chicago
Daniel F. Pachman, M.D., Chicago, *Ex Officio*

Advisory Committee for Heritable Metabolic Diseases
Julian Bierman, M.D., Chicago
Herbert J. Grossman, M.D., Chicago
John B. Hall, M.D., M.P.H., Chicago
Edward F. Lis, M.D., Springfield
Richard A. Morrissey, M.P.H., Chicago
Margaret E. O'Flynn, M.D., Chicago
Daniel J. Pachman, M.D., Chicago
Herbert F. Philipsborn, Jr., M.D., Evanston
James P. Paulissen, M.D., M.P.H., Springfield
Ira M. Rosenthal, M.D., Chicago

Advisory Committee on Pediatric Lead Poisoning
Fred Z. White, M.D., Chillicothe, *Chairman*
A. J. Kiessel, M.D., Decatur, *Vice-Chairman*
Ira M. Rosenthal, M.D., Chicago
Guy A. Pandola, M.D., Joliet
Eleanor Berman, Ph.D., Chicago
Henrietta K. Sachs, M.D., Glencoe
Ronald B. Mack, M.D., Berwyn
Rowine Hayes-Brown, M.D., Chicago
Richard A. Morrissey, Chicago
Verdun Randolph, Springfield
Byron J. Francis, M.D., Springfield
Joyce C. Lashof, M.D., *Ex-Officio*, Springfield

Advisory Committee on Prevention of Accidental Poisoning in Children
Byron J. Francis, M.D., Springfield, *Chairman*
Joseph R. Christian, M.D., Chicago
W. L. Crawford, M.D., Rockford
J. Keller Mack, M.D., Springfield
Paul Pierce, M.D., Alton
John B. Stull, M.D., Olney
Walter M. Whitaker, M.D., Quincy

Youth Camp Advisory Council
Marvin Erdal, Lake Villa
Margaret Keeley, Chicago
Byron Smalley, Oak Brook
Robert Brower, Evanston
William B. Detrich, Hudson

Private Sewage Disposal Code Advisory Cimmittee
Robert Humphrey, North Aurora
Gordon Ytell, Springfield
Larry Sidener, Rochester
Ben Boyd, Normal
Orville Meyer, Wheaton
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Medical Use Advisory Board
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James L. Quinn III, M.D., Chicago
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Lawrence H. Lanzl, Ph.D., Chicago
Jacques Ovadia, Ph.D., Chicago

Advisory Committee for the Child Hearing Test Act
Noel Matkin, Ph.D., *Chairman,* Evanston
James R. Nelson, *Exec. Sec.,* Springfield
Jennifer Buckley, Gurnee
Howard Calvin, Pekin
E. L. Grossner, Springfield
John B. Hall, M.D., Chicago
Kenneth Mangan, Ed.D., Jacksonville
Ralph Naunton, M.D., Chicago
William Plotkin, Ph.D., Chicago
Paul Rittmanic, Ph.D., Dixon
Robert K. Simpson, Ph.D., Champaign

TRAUMA CENTERS IN ILLINOIS

REGIONAL EMERGENCY DIALING. For accident in formation or reporting, call the nearest RED number in your area. This is the emergency switchboard number at the Trauma Center.

1. *Indicates Center offers Emergency Medical Technician—Ambulance (EMT—A) program.*
2. *Indicates center offers Advanced EMT—A Paramedic program***
3. *Indicates center offers Trauma—Critical Nurse Education Programs.*

***Other EMT—A Advanced Programs offered, but not at a trauma center include: Ingalls Memorial Hospital, Harvey; Victory Memorial Hospital, Waukegan; Highland Park Hospital Foundation, Highland Park; Condell Memorial Hospital, Libertyville; St. Francis Hospital, Evanston; McHenry Medical Group, McHenry; and Mercy Hospital, Urbana.*

CITY	TYPE OF TRAINING PROGRAMS AVAILABLE	HOSPITAL	RED NUMBER
Arlington Heights	1, 2	Northwest Community Hospital 800 W. Central Road Arlington Heights 60005	312/259-1000
Aurora		Mercy Center for Health Care Services 1325 No. Highland Avenue Aurora 60506	312/859-2222
Belleville Don Hutchings	1	Memorial Hospital 4501 N. Park Drive Belleville 62223	618/233-7750
Bloomington Ray Burke	1	St. Joseph's Hospital 2200 E. Washington St. Bloomington	309/662-3311
Cairo		Padco Community Hospital 2020 Cedar Street Cairo 62914	618/734-2400
Canton George Inman	1	Graham Hospital Association 210 W. Walnut Street Canton 61520	309/647-5240
Carbondale Charles Loftis	1, 3	Doctors Memorial Hospital 404 W. Main Street Carbondale 62901	618/549-0721
Champaign Dick Jones	1, 3	Burnham City Hospital 311 E. Stoughton St. Champaign 61820	217/337-2500
Chicago		Children's Memorial Hospital 2300 Children's Plaza Chicago 60612	312/649-4000
		Cook County Hospital 1825 W. Harrison Chicago 60612	312/633-6040
Wiley Hall	1	Northwestern University Hospital Spinal Cord Injury Center 250 E. Superior Street Chicago	312/649-2000

CITY	TYPE OF TRAINING PROGRAMS AVAILABLE	HOSPITAL	RED NUMBER
CHICAGO (cont.)			
Jim Hodge	1	Michael Reese Hospital and Medical Center 2929 So. Ellis Ave. Chicago 60616	312/791-2000
	2	Resurrection Hospital 7435 W. Talcott Ave. Chicago 60631	312/774-8000
CHICAGO HEIGHTS James Strickland	1	St. James Hospital 1423 Chicago Road Chicago Heights 60411	312/756-1000
DANVILLE Gene William	1	St. Elizabeth Hospital 600 Sager Avenue Danville 61832	217/442-6300
DECATUR Gil Dixon	1	Decatur Memorial Hospital 2300 N. Edward Street Decatur 62526	217/877-8121
DEKALB	1	DeKalb Public Hospital 680 Haish Boulevard DeKalb 60115	815/758-2431
EAST ST. LOUIS	1	St. Mary's Hospital 129 North 8th Street East St. Louis 62201	618/274-1900
EFFINGHAM Milton Ellefson	1	St. Anothony Memorial Hospital 503 N. Maple Street Effingham 62401	217/342-2121
ELGIN	1, 2	Sherman Hospital Association 934 Center Street Elgin 60120	312/742-9800
ELMHURST John Hunt	1	Memorial Hospital of DuPage Co. 209 Avon Road Elmhurst 60126	312/833-1400
EVANSTON John Priest	1, 3	Evanston Hospital Association 2650 Ridge Avenue Evanston 60201	312/492-2000
FREEPORT Leo Kukla	1	Freeport Memorial Hospital 420 S. Harlem Avenue Freeport 61032	815/233-4131
GALESBURG Larry Higgins	1	St. Mary's Hospital 239 So. Cherry Street Galesburg 61401	309/343-3161
GRANITE CITY Steve Missey	1	St. Elizabeth Hospital 2100 Madison Avenue Granite City 62040	618/876-2020
HARRISBURG Billy Morgan	1	Doctors Hospital of Harrisburg, Inc. 17 Country Club Court Harrisburg 62946	618/253-7671
JACKSONVILLE Don Karcher	1	Passavant Memorial Area Hospital Association 1600 W. Walnut Street Jacksonville 62650	217/245-9541
JOLIET Ted Wilson	1	St. Joseph Hospital 333 N. Madison Street Joliet 60435	815/725-7133
KANKAKEE Manuel Arive	1	St. Mary's Hospital 150 South 5th Avenue Kankakee 60901	815/939-4111

CITY	TYPE OF TRAINING PROGRAMS AVAILABLE	HOSPITAL	RED NUMBER
LaSalle Jim Golasich	1	St. Mary's Hospital 1015 O'Conor Avenue LaSalle 61301	815/223-0607
Lincoln Tom Yocum	1	Abraham Lincoln Memorial Hospital 315—8th Street Lincoln 62656	217/732-2161
Litchfield Fred Long	1	St. Francis Hospital 706 South State Street Litchfield 62056	217/324-2191
Macomb George Inman	1, 2	McDonough County District Hospital 525 E. Grant Street Macomb 61455	309/833-4101
Mattoon Ken Gagnon	1	Memorial District Hospital of Coles County 2101 Champaign Avenue Mattoon 61938	217/234-8881
Maywood Don Poole	1, 2, 3	Foster G. McGaw Hospital Loyola University Medical Center 2160 S. First Avenue Maywood 60153	312/531-3000
Moline Jerry Wolf	1, 3	Moline Public Hospital 635-10th Avenue Moline 61265	309/762-3651
Mt. Vernon Merle Soule	1	Good Samaritan Hospital 605 North 12th Street Mt. Vernon 62864	618/242-4600
Oak Lawn James Strickland	1	Christ Community Hosital 4440 West 95th Street Oak Lawn 60453	312/425-8000
Olney	1	Richland Memorial Hospital 800 E. Locust Street Olney 62450	618/395-2131
		Paris Community Hospital East Court Street Paris 61944	217/465-4141
Peoria Don Libey	1, 3	St. Francis Hospital 530 N.E. Glen Oak Avenue Peoria 61603	309/672-2000
		Pinckneyville Community Hospital 101 N. Walnut Street Pinckeyville 62274	618/357-2187
Pontiac	1	St. James Hospital 610 E. Water Street Pontiac 61764	815/844-5134
Quincy Marvin Reed	1	Blessing Hospital 1005 Broadway Qiuncy 62301	217/223-5811
Rockford Roy Leslie	1	St. Anthony Hospital 5666 E. State Street Rockford 61101	815/226-2000
Springfield Jim Siebert	1, 3	St. John's Hospital 701 E. Mason Street Springfield	217/544-6464
Sterling Billy Boswell	1	Community General Hospital 1601 First Avenue Sterling 61081	815/625-0400
Waukegan Jim Hestad	1	St. Therese Hospital 2611 W. Washington Street Waukegan 60085	312/688-5800
Wood River	1	Wood River Township Hospital Edwardsville Road Wood River 62095	618/254-3821

POISON CONTROL CENTERS IN ILLINOIS

For further information contact:
Byron J. Francis, M.D., M.P.H., Chief
Division of Disease Control
Illinois Department of Public Health
535 W. Jefferson
Springfield, 62761
Phone: (217) 782-3300

ALTON
Alton Memorial Hospital
Memorial Drive
(618) 462-8851

AURORA
Copley Memorial Hospital
Lincoln & Weston Avenues
(312) 897-6021, Ext. 725; 896-3911 Direct line

BELLEVILLE
Memorial Hospital
4501 North Park Drive
(618) 233-7750, Ext. 250

BELVIDERE
Highland Hospital
1625 S. State Street
(815) 547-5441, Ext. 367

BERWYN
MacNeal Memorial Hospital
3249 S. Oak Park Avenue
(312) 797-3000 or 797-3159

BLOOMINGTON
Mennonite Hospital
807 North Main Street
(309) 828-5241, Ext. 395

St. Joseph's Hospital
2200 E. Washington
(309) 662-3311, Ext. 356

CAIRO
Padco Community Hospital
2020 Cedar Street
(618) 734-2400, Ext. 42

CANTON
Graham Hospital Association
210 W. Walnut Street
(309) 647-5240, Ext. 240

CARBONDALE
Doctors Memorial Hospital
404 West Main Street
(618) 549-0721, Ext. 341

CARTHAGE
Memorial Hospital
End of South Adams Street
(217) 357-3131, Ext. 84 or 85

CENTRALIA
St. Mary's Hospital
400 North Pleasant Avenue
(618) 532-6731, Ext. 716

CHAMPAIGN
Burnham City Hospital
407 South 4th
(217) 337-2533

CHANUTE AIR FORCE BASE
United States Air Force Hospital
(217) 495-3133
Limited for treatment of military personnel and families, except for indicated civilian emergencies

CHESTER
Memorial Hospital
1900 State Street
(618) 826-4581

CHICAGO
Master Chicago Center for information, treatment and reference on poisoning:

Rush-Presbyterian-St. Lukes Medical Center
1753 West Congress Parkway
(312) 942-5969

Children's Memorial Hospital
2300 Children's Plaza
(312) 649-4161

Cook County Children's Hospital
700 South Wood Street
(312) 633-6542, 633-6543, or 633-6544

Mercy Hospital and Medical Center
Stevenson Expressway & Martin Luther King Dr.
(312) 567-2017

Michael Reese Medical Center
29th and Ellis Avenue
(312) 791-2810

Mt. Sinai Hospital
California at 15th Street
(312) 542-2030

Resurrection Hospital
7435 West Talcott Avenue
(312) 774-8000, Ext. 401

St. Mary of Nazareth Hospital Center
2233 W. Division Street
(312) 770-2419

South Chicago Community Hospital
2320 East 93rd Street
(312) 978-2000

University of Illinois Hospitals
840 South Wood Street
(312) 996-6885 or 996-6886

Wyler Children's Hospital
950 East 59th Street
(312) 947-6231

DANVILLE
Lake View Memorial Hospital
812 North Logan Avenue
(217) 443-5221

St. Elizabeth Hospital
600 Sager Avenue
(217) 442-6300, Ext. 647, 674 or 736

DECATUR
Decatur Memorial Hospital
2300 North Edward Street
(217) 877-8121, Ext. 676
St. Mary's Hospital
1800 East Lakeshore Drive
(217) 429-2966, Ext. 731, 732, 733 or 742

DES PLAINES
Holy Family Hospital
100 North River Road
(312) 297-1800, Ext. 1000

EAST ST. LOUIS
Christian Welfare Hospital
1509 Martin Luther King Drive
(618) 874-7076, Ext. 216 or 232; 398-1178 Direct line
St. Mary's Hospital
129 North 8th Street
(618) 274-1900, Ext. 204 or 268

EFFINGHAM
St. Anthony Memorial Hospital
503 North Maple Street
(217) 342-2121, Ext. 211 or 212

ELGIN
St. Joseph Hospital
77 Airlite Street
(312) 695-3200 Ext. 348
Sherman Hospital
934 Center Street
(312) 742-9800, Ext. 681

ELMHURST
Memorial Hospital of DuPage County
209 Avon Road
(312) 833-1400, Ext. 550

EVANSTON
Evanston Hospital
2650 Ridge Avenue
(312) 492-6460
St. Francis Hospital
355 Ridge Avenue
(312) 492-2440

EVERGREEN PARK
Little Company of Mary Hospital
2800 West 95th Street
(312) 445 6000, Ext. 221

FAIRBURY
Fairbury Hospital
519 South Fifth Street
(815) 692-2346, Ext. 248

FREEPORT
Freeport Memorial Hospital
420 South Harlem Avenue
(815) 233-4131, Ext. 228

GALESBURG
Galesburg Cottage Hospital
695 North Kellogg
(309) 343-8131, Ext. 356 or 386
St. Mary's Hospital
3333 North Seminary
(309) 343-3161, Ext. 255 or 256

GRANITE CITY
St. Elizabeth Hospital
2100 Madison Avenue
(618) 876-2020, Ext. 421

HARVEY
Ingalls Memorial Hospital
One Ingalls Drive
(312) 333-2300, Ext. 5295

HIGHLAND
St. Joseph's Hospital
1515 Main Street
(618) 654-2171, Ext. 297 or 298

HIGHLAND PARK
Highland Park Hospital
718 Glenview Avenue
(312) 432-8000

HINSDALE
Hinsdale San. & Hospital
120 North Oak Street
(312) 887-2600

HOOPESTON
Hoopeston Community Memorial Hospital & Nursing Home
701 East Orange Street
(217) 283-5531

JACKSONVILLE
Passavant Memorial Area Hospital
1600 West Walnut
(217) 245-9541

JOLIET
St. Joseph Hospital
333 North Madison Street
(815) 725-7133, Ext. 679 or 680
Silver Cross Hospital
1200 Maple Road
(815) 729-7563 or 729-7565

KANKAKEE
Riverside Hospital
350 North Wall Street
(815) 933-1671, Ext. 606
St. Mary's Hospital
500 West Court
(815) 939-4111, Ext. 735

KEWANEE
Kewanee Public Hospital
719 Elliott Street
(309) 853-3361, Ext. 219

LAKE FOREST
Lake Forest Hospital
660 Westmoreland
(312) 234-5600, Ext. 683, 684 or 685

LASALLE
St. Mary Hospital
1015 O'Conor Avenue
(815) 223-0607, Ext. 14

LINCOLN
Abraham Lincoln Memorial Hospital
315 Eighth Street
(217) 732-2161, Ext. 346

MACOMB
McDonough District Hospital
525 East Grant Street
(309) 833-4101, Ext. 433

MATTOON
Memorial Hospital
2101 Champaign Avenue
(217) 234-8881, Ext. 29

MAYWOOD
Loyola University Foster G. McGaw Hospital
2160 South 1st Avenue
(312) 531-3000, Ext. 3374

McHENRY
McHenry Hospital
3516 West Waukegan Road
(815) 385-2200, Ext. 602

MELROSE PARK
Westlake Community Hospital
1225 Superior Street
(312) 681-3000, Ext. 226 or 239

MENDOTA
Mendota Community Hospital
Memorial Drive
(815) 539-7461, Ext. 225

MOLINE
Moline Public Hospital
635—10th Avenue
(309) 762-3651, Ext. 233

MONMOUTH
Community Memorial Hospital
1000 West Harlem Avenue
(309) 734-3141, Ext. 224

MOUNT CARMEL
Wabash General Hospital
1418 College Drive
(618) 263-3112, Ext. 211

MOUNT VERNON
Good Samaritan Hospital
605 North Twelfth Street
(618) 242-4600, Ext. 521

NAPERVILLE
Edward Hospital
South Washington Street
(312) 355-0450, Ext. 326

NORMAL
Brokaw Hospital
Virginia at Franklin Avenue
(309) 829-7685, Ext. 274

OAK LAWN
Christ Community Hospital
4440 West 95th Street
(312) 425-8000, Ext. 382

OAK PARK
West Suburban Hospital
518 N. Austin Boulvard
(312) 383-6200

OLNEY
Richland Memorial Hospital
800 East Locust Street
(618) 395-2131, Ext. 226 or 228

OTTAWA
Community Hospital of Ottawa
1100 E. Norris Drive
(815) 433-3100, Ext. 227 or 228

PARK RIDGE
Lutheran General Hospital
1775 Dempster Street
(312) 696-5151

PEKIN
Pekin Memorial Hospital
14th & Court Streets
(309) 347-1151, Ext. 241

PEORIA
Methodist Hospital of Central Illinois
221 N.E. Glen Oak
(309) 685-6511, Ext. 250 or 360
Proctor Community Hospital
5409 N. Knoxville Avenue
(309) 691-4702, Ext. 791
St. Francis Hospital Medical Center
530 N.E. Glen Oak Avenue
(309) 672-2109, 672-2110 or 672-2111

PERU
Peoples Hospital
925 West Street
(815) 223-3300, Ext. 253

PITTSFIELD
Illini Community Hospital
640 West Washington Street
(217) 285-2113, Ext. 238

PRINCETON
Perry Memorial Hospital
530 Park Avenue East
(815) 875-2811, Ext. 311

QUINCY
Blessing Hospital
1005 Broadway
(217) 223-5811, Ext. 255
St. Mary Hospital
1415 Vermont Street
(217) 223-1200, Ext. 260

ROCKFORD
Rockford Memorial Hospital
2400 N. Rockton Avenue
(815) 968-6861, Ext. 441
St. Anthony Hospital
5666 E. State Street
(815) 226-2041
Swedish-American Hospital
1316 Charles Street
(815) 968-6898, Ext. 534

ROCK ISLAND
Rock Island Franciscan Hospital
2701 17th Street
(309) 793-1000, Ext. 2106

ST. CHARLES
Delnor Hospital
975 N. Fifth Avenue
(312) 584-3300, Ext. 229

SCOTT AIR FORCE BASE
USAF Medical Center
(618) 256-7595

SPRINGFIELD
Memorial Medical Center
First and Miller Streets
(217) 528-2041, Ext. 460
St. John's Hospital
800 East Carpenter
(217) 544-6464, Ext. 210

SPRING VALLEY
St. Margaret's Hospital
600 E. First Street
(815) 663-8161, Ext. 464 or 466

STREATOR
St. Mary's Hospital
111 East Spring Street
(815) 673-2311, Ext. 221

URBANA
Carle Foundation Hospital
611 West Park Avenue
(217) 337-3311
Mercy Hospital
1400 West Park Avenue
(217) 337-2131
WAUKEGAN
St. Therese Hospital
2615 West Washington Street
(312) 688-6470
Victory Memorial Hospital
1324 N. Sheridan Road
(312) 688-6181
WINFIELD
Central DuPage Hospital
0 North, 025 Winfield Road
(312) 653-6900, Ext. 556
WOODSTOCK
Memorial Hospital for McHenry County
527 W. South Street
(815) 338-2500, Ext. 215 or 232
ZION
Zion-Benton Hospital
Shiloh Boulevard
(312) 872-4561, Ext. 239 or 240

LICENSED CLINICAL LABORATORIES

The following is a list of licensed clinical laboratories certified by the Illinois Department of **Public Health** *in states other than Illinois; for a list of Illinois laboratories write IDPH, 525 West Jefferson St., Springfield, IL 62761.*

CALIFORNIA
Berkeley
Solano Laboratories, Inc.
2920 Telegraph Ave., 94705
Newbury Park
Reference Lab., Div. of Abbott Labs.
1011 Rancho Conejo Blvd., 91320
North Hollywood
Biochemical Procedures, Inc.
12020 Chandler Blvd., 91607
Cancer Screening Services
6440 Coldwater Canyon, 91606
Oakland
Endocrine Metabolic Center
3012 Summit St., 94611
San Diego
Pap Smear Center, Inc.
4232 University Ave., 92105
Van Nuys
Bio-Science Labs
7600 Tyrone Ave.
Woodland Hills
Lab Procedures—Div. of Upjohn Co.
6330 Variel Drive, 91364

FLORIDA
Oakland Park
Damon Medical Laboratory
3290 Northeast 12th Ave., 33308
Tampa
Patterson Coleman Laboratories, Inc.
4708 N. Armenia, 33603

INDIANA
Evansville
Mid-America Path. Serv., Inc.
3700 Bellemeade Ave., 47715
Jeffersonville
Physicians Precision Automated Labs
3408 Industrial Parkway, 47130

IOWA
Davenport
Quad Cities Pathologists Group
1814 East Locust, 53803

KANSAS
Lenexa
Home Office Reference Lab.
9900 Pflumm Road, 66215
Wichita
Associated Labs., Inc.
511 E. 21st St., 67208

KENTUCKY
Louisville
Clinical Diagnostic Labs., Inc.
634 South Floyd Street, 40202

MASSACHUSETTS
Boston
Clin-Chem Labs., Inc.
1106 Commonwealth Ave., 02215
Needham Heights
Damon Medical Labs, Inc.
115 4th Ave., 02194
Waltham
Boston Medical Lab. Inc.
15 Lunda St., 02154

MICHIGAN
Grand Rapids
Continental Bio-Cln
2823 Clydon S.W., 49509

MINNESOTA
Rochester
Mayo Medical Service Ltd.
200 First St. S.W., 55901

MISSOURI
Clayton
Cooper Medical Laboratory
141 N. Meramic, 63105
Raytown
National Medical and Underwriting Lab.
8800 E. 63rd St., 64133
St. Louis
Allen Medical Labs., Ltd.
2821 N.Ballas Rd., 63131
Clinical Labs of St. Louis, Inc.
11636 Administration Dr., 63141
Miller Labs., Inc.
716 Hanley Industrial Ct. Dr., 63144
Midwest Medical Laboratory, Inc.
4141 Forest Park Blvd., 63108
Missouri Clin. & Biochem Lab.
4910 Forrest Park Blvd., 63108
Pathology Services
716 Hanley Industrial Ct. Dr. 63144

NEW JERSEY

HACKENSACK

Metpath, Inc.
60 Commerce Way, 60606

METUCKEN

Center for Lab Medicine
16 Pearl St., 08840

NEWARK

GIB Labs., Inc.
213 Washington St., 07101

NORTH CAROLINA

BURLINGTON

Biomedical Laboratories, Inc.
1308 Rainey St., 27215

OHIO

COLUMBUS

Automated Medical Service of Ohio, Inc.
1466 S. High St., 43207

DUBLIN

Consolidated Biomed Labs., Inc.
6370 Wilcox Road, 43017

MANSFIELD

Automated Medical Services of Ohio, Inc.
666 Park Ave., West, 44906

POWELL

Searle Diagnostic, Inc.
2775 Home Road, 43065

OREGON

PORTLAND

Lancet Laboratories
2 Plaza S.W., 6900 S.W. Haines Road, 97223

ICN Medical Labs., Inc.
10700 N.E. Sandy Blvd., 97220

ICN Medical Labs., Inc.
6060 N. 112th, 97208

SOUTH DAKOTA

SIOUX FALLS

Lab of Clinical Medicine
1212 So. Euclid Ave., 57105

TENNESSEE

MEMPHIS

Memphis Pathology Lab
257 S. Bellevue, 38104

TEXAS

DALLAS

Bio-Assay Lab., Inc.
7035 Carpenter Freeway, 75247

Complete Clinical Lab., Inc.
3707 Gaston Ave., 75246

Southwest Medical Lab., Inc.
1111 W. Mockingbird Lane, 75247

WISCONSIN

MILWAUKEE

Drug I.D. Laboratory, Inc.
4608 W. Burleigh St., 53210

APPROVED RENAL DIALYSIS FACILITIES, CENTERS AND DIRECTORS

Illinois Department of Public Health
Division of Disease Control

Michael Reese Hospital and Medical Center
29th Street and Ellis Ave., Chicago 60616
Fredric L. Coe, M.D.

Rush-Presbyterian-St. Luke's Medical Center
1753 West Congress Parkway, Chicago 60612
Jimmie Roberts, M.D.

Washington University Renal Unit
Chromalloy American Kidney Center
(Barnes Hospital)
4949 Barnes Hospital Plaza, St. Louis, Mo. 63110
Eduardo Slatopolsky, M.D.

The Jewish Hospital of St. Louis
216 South Kingshighway, St. Louis, Mo. 63110
Herbert Lubowitz, M.D.

Springfield Medical Center
First and Miller Sts., Springfield 62701
Richard Bilinsky, M.D.

Evanston Hospital
2650 Ridge Ave., Evanston 60201
Bernard Adelson, M.D.

University Hospitals
Department of Medicine
1300 University Ave., Madison, Wis. 53706
Arvin B. Weinstein, M.D.

University of Illinois Research and Educational Hospitals
840 South Wood St., Chicago 60612
Franklin Schwartz, M.D.

Mayo Clinic
Internal Medicine & Nephrology, Rochester, Minn. 55901
William J. Johnson, M.D.

University of Chicago Hospitals & Clinics
(Includes LaRabida Sanitarium
Ronald Kallen, M.D.)
950 East 59th St., Chicago 60649
Adrian Katz, M.D.

Mt. Sinai Hospital Medical Center
Fifteenth and California Aves., Chicago 60608
Earl C. Smith, M.D.

Northwestern Medical Center
Passavant Memorial Hospital
303 East Superior St., Chicago 60611
Francesco del Greco, M.D.

West Suburban Hospital and West Suburban Kidney Center, Inc.
518 North Austin Blvd., Oak Park 60302
Robert C. Muehrcke, M.D.

Rockford Memorial Hospital
2300 North Rockton Ave, Rockford 61101
Ewald T. Sorensen, M.D.

Cook Country Hospital
1825 West Harrison St., Chicago 60612
George Dunea, M.D.

St. Francis Hospital
523 N.E. Glen Oak, Peoria 61603
Robert Pflederer, M.D.

The Children's Memorial Hospital
2300 Children's Plaza, Chicago 60614
Peter R. Lewy, M.D.

Lake View Memorial Hospital
812 North Logan Ave., Danville 61832
Raja M. Sadiq, M.D.

Mercy Hospital
1400 West Park Ave., Urbana 61801
R. E. Tirona, M.D.

St. Joseph Hospital
2900 North Lake Shore Dr., Chicago 60657
Gordon Lang, M.D.

Galesburg Cottage Hospital
674 North Seminary St., Galesburg 61401
Agha Babanoury, M.D.

Roosevelt Memorial Hospital
426 West Wisconsin St., Chicago 60614
Franklin D. Schwartz, M.D.

Ingalls Memorial Hospital
One Ingalls Drive, Harvey
Alexander B. White, M.D.

Doctors Memorial Hospital
404 West Main St., Carbondale 62901
John Taylor, M.D.

Blessing Hospital
1005 Broadway, Quincy 62301
Hugh Espey, M.D.

Jefferson County Memorial Hospital
909 Shawnee St., Mt. Vernon 62864
Robert Parks, M.D.

Victory Memorial Hospital
1324 North Sheridan Rd., Waukegan 60085
John Freeland, M.D.

Central DuPage Hospital
0 North 025 Winfield Rd., Winfield 60190
Paul Balter, M.D.

Loyola University (Foster G. McGaw) Hospital
2160 South First Ave., Maywood 60153

St. Margaret Hospital
25 Douglas St., Hammond, Ind. 46320
James H. Greenwald, M.D.

Edgewater Hospital
5700 N. Ashland, Chicago 60660
Gabriel Schwartz, M.D.

St. Elizabeth's Hospital
211 S. Third St., Belleville 62221
Joseph Santiago, M.D.

Silver Cross Hospital
600 Walnut St., Joliet 60432
Robert S. Markelz, M.D.

Christ Community Hospital
4440 W. 95th St., Oak Lawn 60453
Joseph H. Oyama, M.D.

Memorial Hospital of DuPage
209 Avon Road, Elmhurst 60126
John Simonaitis, M.D.

Good Samaritan Hospital
Vincennes, Indiana 47591
John S. Murray, M.D.

St. Louis Children's Hospital
500 S. Kingshighway, St. Louis, Mo. 63110
Alan M. Robson, M.D.

Dialysis for Veterans with kidney disease is available at:

Veterans Administration Hospital, Hines 60141

Veterans Administration Research Hospital, Chicago 60611
Peter Ivonovich, M.D.

Satellites or Limited Care Facilities

West Suburban Kidney Center

St. Peter's Evangelical Lutheran Church
500 Hannah, Forest Park 60130

Lombard Unit
First Church of Lombard, Lombard 60148

Chicagoland Dialysis Center
Cathedral Shelter
Ashland and Adams, Chicago 60607
Robert C. Muehrcke, M.D.

University of Illinois Hospitals

Dialysis Centers, Limited
1200 North LaSalle St., Chicago 60610
740 N. Rush St., Chicago 60610

Springfield Medical Center

St. Mary's Hospital
1415 Vermont Street, Quincy 62301

Renal Facility
913 N. Rutledge, Springfield 62702

Alton Memorial Hospital
Alton 62002

Doctors' Park
701 North Walnut St., Springfield 62702

Douglas Nursing Home
Mattoon Memorial Hospital, Mattoon 61938

Decatur Memorial Hospital
Decatur 62521

Norris Hospital
Jacksonville 62650

Evanston Hospital Dialysis Center

Niles-Day-Springman Satellite
Lawrencewood Shopping Center
Waukegan Rd., Niles 60648
Walid Ghantous, M.D.

North Central Dialysis Centers

14 East Jackson, Chicago 60610
Alan Kanter, M.D.

For further information contact:

Mrs. Ruth S. Shriner, ACSW—Coordinator Direct Services
Programs, Illinois Department of Public Health
Room 150, 535 West Jefferson Street, Springfield 62706
Phone (217) 782-3303

ARTIFICIAL KIDNEYS FOR ACUTE POISONING CASES

Copley Memorial Hospital Lincoln & Weston Avenues Aurora	Phone: Person in Charge: Location in Hosp:	897-6021 M. J. Carbon, M.D. Intermediate Care
St. Elizabeth's Hospital 211 S. 3rd Street Belleville	Phone: Person in Charge: Location in Hosp:	234-2120, Ext. 285 Joseph Santiago, M.D. Sister Jamesine Lamb, R.N. Hemodialysis Unit
St. Francis Hospital 12935 S. Gregory Blue Island	Phone: Person in Charge: Location in Hosp:	597-2000 Dr. Otero Intensive Care Unit
Doctors Memorial Hospital 404 West Main Carbondale	Phone: Person in Charge: Location in Hosp:	549-0721 M. Wekel, M.D. Renal Dialysis
Burnham City Hospital 407 S. Fourth Street Champaign	Phone: Person in Charge: Location in Hosp:	337-2500 Reynaldo Tirona, M.D. Trauma Center—ICU Unit
Chicago Osteopathic Medical Center 5200 S. Ellis Avenue Chicago	Phone: Person in Charge: Location in Hosp:	363-6800 Donald Hollandsworth, D.O. Renal Medicine
Children's Memorial Hospital 2300 Children's Plaza Chicago	Phone: Person in Charge: Location in Hosp:	649-4000 Peter Lewy, M.D. Nephrology
Columbus Hospital 2520 N. Lakeview Avenue Chicago	Phone: Person in Charge: Location in Hosp:	883-6427 Gordon Lang, M.D. Intensive Care Unit
Cook County Hospital 1825 West Harrison Chicago	Phone: Person in Charge: Location in Hosp:	633-6000 George Dunea, M.D. Nephrology-Internal Medicine
Edgewater Hospital 5700 N. Ashland Avenue Chicago	Phone: Person in Charge: Location in Hosp:	878-6000 Gabriel Schwartz, M.D. Nephrology
Mercy Hospital & Medical Center Stevenson Expressway at King Drive Chicago	Phone: Person in Charge: Location in Hosp:	567-2000 Carlos Otero, M.D. Intensive Care Unit
Michael Reese Hosp. & Medical Center 2900 S. Ellis Chicago	Phone: Person in Charge: Location in Hosp:	791-2242 B. Levin, M.D. Dialysis Section Dept.
Mt. Sinai Hospital Medical Center of Chicago 15th & California Avenue Chicago	Phone: Person in Charge: Location in Hosp:	542-2000 Earl Smith, M.D. Hemodialysis Unit
Northwest Hospital Inc. 5645 W. Addison St. Chicago	Phone: Person in Charge: Location in Hosp:	282-7000 Jayme Neuman, M.D. Intensive Care
Northwestern Memorial Hospital Superior & Fairbanks Court Chicago	Phone: Person in Charge: Location in Hosp:	649-3327 Francesco delGreco, M.D. Dialysis Dept.
Rush-Presbyterian-St. Luke's 1753 West Congress Parkway Chicago	Phone: Person in Charge: Location in Hosp:	942-5000 Jimmie Roberts, M.D. Dialysis Unit, Nephrology
Ravenswood Hospital Medical Center 4550 N. Winchester Chicago	Phone: Person in Charge: Location in Hosp:	878-4300 Gordon Lang, M.D. Medicine
Roosevelt Memorial Hospital 426 W. Wisconsin Chicago	Phone: Person in Charge: Location in Hosp:	751-4000 J. Feldstein, M.D. Dialysis

St. Joseph Hospital 2900 N. Lake Shore Drive Chicago	Phone: Person in Charge: Location in Hosp:	975-3027 Gordon Lang, M.D. Renal Dialysis
University of Chicago Hospital & Clinics 950 E. 59th Chicago	Phone: Person in Charge: Location in Hosp:	947-1000 Adrian Katz, M.D. Kidney Dialysis Lab.
University of Illinois Hospital 840 S. Wood St. Chicago	Phone: Person in Charge: Location in Hosp:	996-7000 Neil A. Kurtzman, M.D. Medicine
Lake View Memorial Hospital 812 N. Logan Avenue Danville	Phone: Person in Charge: Location in Hosp:	443-5000 Sharon Tuggle, R.N. Intensive Care & Hemodialysis Unit
St. Joseph Hospital 77 Airlite Elgin	Phone: Person in Charge: Location in Hosp:	695-3200 Gerald Pearson Emergency Dept.
Sherman Hospital 934 Center Street Elgin	Phone: Person in Charge: Location in Hosp:	742-9800 Nasir Ahmad, M.D. Nursing Dept.
Alexian Brothers Medical Center 800 W. Biesterfield Road Elk Grove Village	Phone: Person in Charge: Location in Hosp:	437-5500 Paul Balter, M.D. Renal Dialysis Unit
Memorial Hospital of DuPage Co. 209 Avon Road Elmhurst	Phone: Person in Charge: Location in Hosp:	833-1400 Mrs. O. Pupp, Head Nurse Renal Dialysis
Evanston Hospital 2650 Ridge Avenue Evanston	Phone: Person in Charge: Location in Hosp:	492-2000 Dr. Salkin Hemodialysis
St. Francis Hospital of Evanston 355 Ridge Avenue Evanston	Phone: Person in Charge: Location in Hosp:	492-4000 John O'Malley Intensive Care Unit
Freeport Memorial Hospital 420 South Harlem Avenue Freeport	Phone: Person in Charge: Location in Hosp:	233-4131 C. W. Metcalf, M.D. Inhalation Therapy
Galesburg Cottage Hospital 695 N. Kellogg Galesburg	Phone: Person in Charge: Location in Hosp:	343-8131 Agha Babanoury, M.D. Hemodialysis Unit
Ingalls Memorial Hospital One Ingalls Drive Harvey	Phone: Person in Charge: Location in Hosp:	333-2300 Barbara Nelson, R.N. Renal Dialysis
Silver Cross Hospital 1200 Maple Road Joliet	Phone: Person in Charge: Location in Hosp:	729-7111 R. A. Markelz, M.D. Renal Dialysis
St. Mary's Hospital 500 W. Court Street Kankakee	Phone: Person in Charge: Location in Hosp:	939-4111 T. Basu, M.D. Dialysis Unit
Foster G. McGaw Hosp. of Loyola University 2160 South 1st Avenue Maywood	Phone: Person in Charge: Location in Hosp:	531-3000 Austin Currens Renal Dialysis
Jefferson Memorial Hospital 909 Shawnee Mt. Vernon	Phone: Person in Charge: Location in Hosp:	242-3400 Barbara Cailteux, R.N. Kidney Dialysis Unit
West Suburban Hospital 518 N. Austin Blvd. Oak Park	Phone: Person in Charge: Location in Hosp:	383-6200 Zoe Morrissey, R.N. Kidney Dialysis Center
Christ Community Hospital 4440 West 95th St. Oak Lawn	Phone: Person in Charge: Location in Hosp:	425-8000 Joseph Oyama, M.D. Hemodialysis

Methodist Hospital of Central Illinois 221 N.E. Glen Oak Ave. Peoria, Illinois 61603	Phone:	685-6511
	Person in Charge:	Miss M. Fritz, R.N. J. Meyers, M.D.
	Location in Hosp:	Medicine
St. Francis Hospital Medical Center 530 N.E. Glen Oak Peoria	Phone:	672-2000
	Person in Charge:	R. A. Pflederer, M.D.
	Location in Hosp:	Hemodialysis
Lutheran General Hospital 1775 Dempster Street Park Ridge	Phone:	696-2210
	Person in Charge:	Margaret Bischel, M.D.
	Location in Hosp:	Medicine
Blessing Hospital 1005 Broadway Quincy	Phone:	223-5811
	Person in Charge:	Mrs. Marian Almasey, R.N.
	Location in Hosp:	Renal Dialysis
Rockford Memorial Hospital 2400 N. Rockton Ave. Rockford	Phone:	968-6861
	Person in Charge:	E. T. Sorensen, M.D.
	Location in Hosp:	Renal Dialysis
Memorial Medical Center 1st & Miller Springfield	Phone:	528-2041
	Person in Charge:	Dr. Richard Bilinsky
	Location in Hosp:	Renal Unit
Mercy Hospital 1400 West Park Urbana	Phone:	337-2284
	Person in Charge:	R. F. Tirona, M.D. and Dr. Humphreys Mr. Michael Lueth
	Location in Hosp:	Hemodialysis Unit
Victory Memorial Hospital 1324 North Sheridan Road Waukegan	Phone:	688-3000
	Person in Charge:	John P. Freeland, M.D.
	Location in Hosp:	Dialysis Unit
Central DuPage Hospital 0 N 025 Winfield Road Winfield	Phone:	653-6900
	Person in Charge:	P. Balter, M.D.
	Location in Hosp:	Kidney Dialysis

In addition to the hospitals in Illinois, we have also received information that the following hospital has an artificial kidney. This out of state hospital may be more accessible in some emergencies than those in Illinois:

Barnes Hospital 4949 Barnes Hospital Plaza St. Louis, Missouri	Phone:	454-2000
	Person in Charge:	Dr. Edwardo Slatapolsky
	Location in Hosp:	2nd Floor

DEPARTMENT OF REGISTRATION AND EDUCATION

628 East Adams Street, Springfield
Ronald E. Stackler, *Director*
Jacob M. Shapiro, *Chief Counsel*
Jerry D. Sternstein, *Deputy Director-Licensing*
James L. Pandolfi, *Deputy Director-Management*

The department is primarily concerned with the registration, licensing and enforcement of 33 laws governing the different professions, trades and occupations, including the Medical Practice Act. Enforcement of the Medical Practice Act is in the Division of Professional Supervision headed by a coordinator. Registration and licensing is under the jurisdiction of the Division of Registration.

The Medical Examining Committee appointed by the director of the department operates within the framework of the act and is charged with the responsibility of giving examinations for licensure, hearing complaints for revocation and suspension of licenses and promulgating rules and regulations for the administration of the act.

Medical Examining Committee

Dale E. Richardson, D.O., Pontiac, *Chairman*
Paul Tullio, D.C., Chicago
Basil Chronis, M.D., Palos Heights
Lester Nathan, M.D., Skokie
Robert S. Mendelsohn, M.D., Evanston
Mays C. Maxwell, M.D., East St. Louis
Luis Yarzagaray, M.D., Maywood

Medical Practice Act

LICENSING AND ENFORCEMENT PROCEDURES

Illinois statutes provide for licensing of physicians to practice medicine "(1) in all of its branches, and (2) licensing of those persons to treat human ailments without the use of drugs or medicine and without operative surgery."

The Medical Practice Act states, "no person shall practice medicine, or any of its branches, or midwifery, or any system or method of treating human ailments without the use of drugs or medicines and without operative surgery, without a valid existing license so to do." Applicant for license must pass an examination of his qualifications which must be satisfactory to the Department of Registration and Education.

This act does not prohibit the practice of medicine by a person who is licensed to practice medicine in all of its branches in any other state of the United States or the District of Columbia who has applied in writing to the Department, in form and substance satisfactory to the Department, for a license to practice medicine in all of its branches and has complied with all of the provisions of Section 13, except the passing of an examination which may be given under Section 13, until:

(a) the expiration of 6 months after the filing of such written application, or

(b) the decision of the Department that the applicant has failed to pass an examination within 6 months or failed without an approved excuse to take an examination conducted within 6 months by the Department, or

(c) the withdrawal of the application. (Added by Act approved July 26, 1971)

Any person licensed under this Act who dispenses any drug or medicine shall affix to the box, bottle, vessel or package containing the same a label indicating (a) the date on which such drug or medicine is dispensed; (b) the last name of the person dispensing such drug or medicine; (c) the directions for use thereof; and (d) the proprietary name or names or, if there is none, the established name or names of the drug or medicine, the dosage and quantity, unless the person dispensing the drug or medicine determines that the health of the person to whom the drug or medicine is dispensed requires that such information be omitted. This Section shall not apply to drugs or medicines in a package which bears a label of the manufacturer containing information describing its contents which is in compliance with requirements of the Federal Food, Drug and Cosmetic Act and the Illinois Food, Drug and Cosmetic Act and which is dispensed without consideration by a practitioner licensed under this Act. "Drug" and "medicine" have the meaning ascribed to them in the "Pharmacy Practice Act," approved July 11, 1955, as now or hereafter amended. (Added by Act approved September 24, 1971)

Minimum standards of professional education. Except as provided in Section 9a of this Act, the minimum standards of professional education to be enforced by the department in conducting examinations and issuing licenses shall be as follows:

1. *Practice of Medicine.* For the practice of medicine in all of its branches:

(a) For an applicant who is a graduate of a medical college before the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to graduation a 4 years' course of instruction of not less than 9 months each, in such medical college, or its equivalent, the time elapsing between the beginning of the first year and the ending of the fourth year having been not less than 40 months, and which was reputable and in good standing in the judgment of the department; and prior to taking such examination said applicant must present proof that he has completed a 4 years' course of instruction in a high school or its equivalent as determined by an examination conducted by the department.

(b) For an applicant who is a graduate of a medical college after the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to admission thereto 2 years' course of instruction in a college of liberal arts, or its equivalent, or in such medical college, and a course of instruction in a medical college in the treatment of human ailments, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, and in addition thereto, a course of clinical training of not less than 12 months in a hospital, such college of libreputable and in good standing in the judgment of eral arts, medical college and hospital having been the department.

The time requirement of not less than 132 weeks within a period of 35 months, set forth above, may be reduced by the department upon recommendation of the Dean of the medical school in the case of programs involving students with advanced standing. (added by Act approved July 26, 1971).

(c) For an applicant who is a graduate of a medical college or school in another country; that such applicant was a resident of this State for a period of five years prior to matriculating in such medical college or school; that such applicant completed a required course of instruction in the treatment of human aliments as offered by such college or school of medicine, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35

months; that such applicant has completed a minimum of three years course of instruction in an accredited college of liberal arts or its equivalent; that such applicant submit an application to an Illinois medical school and submit to such testing procedures, including use of nationally recognized medical student tests and/or tests devised by the individual medical school, to determine equivalency of education compared to state norms, such testing could be utilized in placement of such applicant at a level appropriate to educational achievement; that such applicant may be placed by an Illinois medical school into the appropriate level of medical school, thru internship training, provided that applicant agrees to pay, either by a scholarship or some other personal means, such tuition and fees necessary to complete medical education, and provided that such applicant signs a statement in a form to be determined by the Department that upon successful completion of all licensure requirements applicant intends to practice medicine in this State. Upon completion of such course or activity of didactic and medical training as specified by an accepting medical school, applicant shall be eligible for award of an M.D. degree and examination and licensing for the practice of medicine in all of its branches as provided in this act and upon payment of the fee provided in paragraph (a) of sub-section 4 of Section 4 of this Act.

(d) Until September 1, 1978, for an applicant who has studied medicine at a medical college or school located outside the United States; that such applicant has completed all of the formal requirements of a foreign medical school except internship and/or social service, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months; that such applicant has completed a minimum of 3 years course of instruction in an accredited college of liberal arts or its equivalent; that such an applicant has submitted an application to a medical school recognized by the Department and submitted to such evaluation procedures, including use of nationally recognized medical student tests and/or tests devised by the individual medical school and that such applicant has satisfactorily completed one academic year of supervised clinical training under the direction of such medical school; and, after completion of said academic year of supervised clinical training, that such applicant has satisfactorily completed twelve months of post graduate training in an approved hospital having been repeutable and in good standing in the judgment of the Department; and provided that such applicant sign a statement and a form, to be determined by the Department, that upon successful completion of all license requirements, applicant intends to practice medicine in this state. Upon completion of such course or activity of didactic and medical training as specified by an accepting medical school, applicants shall be eligible for examination and licensing for the practice of medicine in all of its branches as provided in this Act and upon payment of the fee provided in paragraph (a) of sub-section 4 of Section 4 of this Act.

Until September 1, 1978, satisfaction of the requirements of this sub-section shall be in lieu of the completion of any foreign internship and/or social service requirements, and no such requirements shall be a condition of licensure as a physician in this State.

Until September 1, 1978, satisfaction of the requirements of this sub-section shall be in lieu of certification by the Educational Council for Foreign Medical Graduates, and such certification shall not be a condition of licensure as a physiican in this State for candidates who have completed the requirements of this sub-section.

Until September 1, 1978, no hospital licensed by the State, or operated by the State or political subdivision thereof, or which receive State financial assistance, directly or indirectly, shall require an individual who at the time of his enrollment in a medical school outside the United States is a citizen of the United States, to satisfy any requirement other than those contained in this sub-section prior to commencing an internship or residency.

Until September 1, 1978, a document granted by a medical school located outside the United States which certifies completion of all of the formal training requirements of such foreign medical school except internship and/or social service; and satisfactory completion of the examination and academic year of supervised clinical training at a medical school recognized by the Department referred to in this sub-section shall be deemed the equivalent of the degree of Doctor of Medicine for purposes of licensure and practice as a physician in this State and shall possess all the rights and privileges thereof.

The Illinois Board of Higher Education may make grants to Illinois Medical Schools, public and private, for each applicant who commences his academic year of supervised clinical training under the direction of said medical school. Preference shall be given in the award of these grants to Illinois residents. The Illinois Board of Higher Education shall by regulation adopt reasonable guidelines for the distribution of funds authorized by this Act. (Added by Act approved Sept. 7, 1974).

2. *Treating human ailments without drugs or medicines and without operative surgery.* For the practice of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery:

(a) For an applicant who was a resident student and who is a graduate before July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments, which he specifically designated in his application as the one he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to graduation a 3 years' course of instruction of not less than 6 months each, the time elapsing between the beginning of the first year and the ending of the third year having been not less than 22 months, and which are reputable and in good standing in the judgment of the department and prior to taking the examination the applicant must

present proof that he has completed a 4 years' course of instruction in high school, or its equivalent, as determined by an examination conducted by the department.

(b) For an applicant who was a resident student and who is a graduate after July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments which he specifically designated in his application as the one which he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to admission thereto a 4 years' course of instruction in a high school, and as a prerequisite to graduation therefrom a course of instruction in the treatment of human ailments, of not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months except that as to students matriculating or entering upon a course of study of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery during the years 1940, 1941, 1942, 1943, 1944, 1945, 1946 and 1947, the said elapsed time shall be not less than 32 months, such high school and such school, college, institution having been reputable and in good standing in the judgment of the department.

(c) For an applicant who is a matriculant in a chiropractic college after September 1, 1969, that such applicant shall be required as a prerequisite for admission to examine for licensure, to complete a 2 years' course of instruction in a liberal arts college or its equivalent, and a course of instruction in a chiropractic college in the treatment of human ailments, such course as a prerequisite to graduation therefrom having been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, such college of liberal arts and chiropractic college having been reputable and in good standing in the judgment of the Department.

3. *Midwifery.* For the practice of midwifery: That he be a graduate of a college of midwifery which requires as a prerequisite to admission thereto, a one year's course of instruction in a high school or its equivalent, and required as a prerequisite to graduation, a one year's course in such college of midwifery, the time actually spent under instruction in such college of midwifery to have been not less than 12 months; such high school or equivalent school, and such college of midwifery having been in good standing in the judgment of the department.

Without prejudice to licenses heretofore issued under this section, no further licenses shall be issued under this section after the effective date of this amendment. As amended by act approved Aug. 2, 1965.

All examinations provided for by the Medical Practice Act shall be conducted by the Department of R&E. Examinations of applicants who seek to practice medicine in all of its branches shall embrace the subjects of which knowledge is generally required of candidates for the degree of Doctor of Medicine by reputable medical colleges in the U.S., and shall be such in the judgment of the Department of R&E that as will determine the qualifications of applicants to practice medicine in all of its branches.

Every license issued under the Act expires on July 1 of each even-numbered year. Every licensee under the Act may, biennially during the month of June of each even-numbered year, renew his license upon paying to the Department a renewal fee of $10.

Revocation and Suspension of License or Certificate

The Department may revoke, or suspend, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to the license, certificate or state hospital permit of any person issued under this Act or under any other Act in this State to practice medicine, to practice the treatment of human ailments in any manner or to practice midwifery, or may refuse to grant a license, certificate or state hospital permit under this Act or may grant a license, certificate or state hospital permit on a probationary status subject to the limitations of the probation, and may cause any license or certificate which has been the subject of formal disciplinary procedure to be marked accordingly on the records of any county clerk upon the following grounds:

"1. Conviction of procuring or attempting or aiding to procure such an abortion as was made unlawful at the time under the Criminal Code of this State;

2. Conviction in this or another state of any crime which is a felony under the laws of this state or conviction of a felony in a federal court, if the Department determines, that after investigation, that such person has not been sufficiently rehabilitated to warrant the public trust; (as amended by Act approved July 23, 1971).

3. Gross malpractice resulting in permanent injury or death of a patient;

4. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud, or harm the public;

5. Obtaining a fee, either directly or indirectly, either in money or in the form of anything else of value or in the form of financial profit as personal compensation, or as compensation, charge, profit or gain for an em-

ployer or for any other person or persons, on the fraudulent representation that a manifestly incurable condition of sickness, disease or injury of any person can be permanently cured;

6. Habitual intemperance in the use of ardent spirits, narcotics, or stimulants to such an extent as to incapacitate for performance of professional duties;

7. Holding one's self out to treat human ailments under any name other than his own, or the personation of any other physician;

8. Employment of fraud, deception or any unlawful means in applying for or securing a license, certificate, or state hospital permit to practice the treatment of human ailments in any manner, to practice midwifery, or in passing an examination therefor, or willful and fraudulent violation of the rules and regulations of the department governing examinations;

9. Holding one's self out to treat human ailments by making false statements, or by specifically designating any disease, or group of diseases and making false claims of one's skill or the efficacy or value of one's medicine, treatment or remedy therefor;

10. Professional connection or association with, or lending one's name to, another for the illegal practice by another of the treatment of human ailments as a business, or professional connection or association with any person, firm, or corporation holding himself, themselves, or itself out in any manner contrary to this Act;

11. Revocation or suspension of a medical license in a sister state;

12. A violation of any provision of this Act or of the rules and regulations formulated for the administration of this Act;

13. Except as otherwise provided in Section 16.01, advertising or soliciting by himself or through another, by means of hand bills, posters, circulars, stereopticon slides, motion pictures, radio, newspapers or in any other manner for professional business."

14. A finding by the Committee that the registrant after having his license placed on probationary status violated the terms of the probation.

All proceedings to suspend, revoke, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to a license, certificate or state hospital permit on any of the foregoing grounds, except the ground numbered 8 (fraudlent groups expected) must be commenced within 3 years next after the conviction or commission of any of the acts described therein, except as otherwise provided by law; but the time during which the holder of the license, certificate or state hospital permit was without the State of Illinois shall not be included within the 3 years.

The entry of a decree by any circuit court establishing that any person holding a license, certificate or state hospital permit under this Act is a person in need of mental treatment operates as a suspension of that license, certificate or state hospital permit. That person may resume his practice only upon a finding by the Committee of Physicians that he has been determined to be recovered from mental illness by the court and upon the Committee's recommendation that he be permitted to resume his practice. (added by Act approved July 26, 1971).

15. Directly or indirectly giving to or receiving from any physician, person, firm or corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered. Nothing contained in this subsection prohibits persons holding valid and current licenses under this Act from practicing medicine in partnership under a partnership agreement or in a corporation authorized by "The Medical Corporation Act" as now or hereafter amended or as an association authorized by "The Professional Association Act" as now or hereafter amended, or under "The Professional Corporation Act" as now or hereafter amended, from pooling, sharing, dividing or apportioning the fees and monies received by them or by the partnership, corporation or association in accordance with the partnership agreement or the policies of the Board of Directors of the corporation or association. Nothing contained in this subsection shall abrogate the right of two or more persons holding valid and current licenses under this Act to receive adequate compensation for concurrently rendering professional services to a patient and divided a fee: provided, the patient has full knowledge of the division, and provided that the division is made in proportion to the services performed and responsibility assumed by each. (added by Act approved July 31, 1971).

Section 16.01. Any person licensed under this Act may list his name, title, office hours, address, telephone number and any specialty in professional and telephone directories; may announce by way of a professional card not larger than 3½ inches by 2 inches, only his name, title, degree, office location, office hours, phone num-

ber, residence address and phone number and any specialty; may list his name, title, address and telephone number and any specialty in public print limited to the number of lines necessary to state that information; may announce his change of place of business; absence from, or return to business in the same manner; or may issue appointment cards to his patients, when information thereon is limited to the time and place of appointment and that information permitted on the professional card. Listings in public print, in professional and telephone directories, or announcements of change of place of business, absence from, or return to business, may not be made in bold faced type.

Rules and Regulations Adopted for the Administration of the Illinois Medical Practice Act, Effective March 18, 1955

RULE I—ACCREDITED COLLEGES OF MEDICINE AND SURGERY

Medical colleges having rules and curricula commensurate with and equivalent to the rules and curricula of the College of Medicine of the University of Illinois, will be considered for accreditation by the Department of Registration and Education.

RULE II—ACCREDITED COLLEGES TEACHING SYSTEMS OF TREATING HUMAN AILMENTS WITHOUT THE USE OF DRUGS OR MEDICINE AND WITHOUT OPERATIVE SURGERY.

A professional college or institution teaching a system of treating human ailments without the use of drugs or medicine and without operative surgery shall be deemed reputable and in good standing in the judgment of the Department upon submission of proof of the following requirements:

(a) That a Dean or other Executive Officer, employed on a full-time basis supervises the students and curriculum.

(b) That the faculty is comprised of graduates in their specialty from recognized professional colleges or institutions.

(c) That the faculty is organized and each department has a director, professors, associate professors and assistant professors, each responsible to his superior for his instruction in the particular subject he teaches.

(d) That, annually, a catalogue or brochure is published setting forth the requisites for admission to the college, tuition rates, courses offered, dates of sessions, schedule of classes, requirements for graduation, a roster of the undergraduate students and a roster of the last graduating class. The catalogue or brochure shall contain a list of the departments of the school, the titles of the personnel and a brief summary of each person's qualifications. The curriculum shall include, but not be limited to, four academic years' instruction in the following subjects:

(1) Anatomy
 (a) Embryology; (b) Histology; (c) Neuroanatomy
(2) Physiology and Chemistry
(3) Pathology and Bacteriology
(4) Diagnosis
 (a) Physical; (b) Differential; (c) Laboratory

(e) That suitable buildings provided with laboratories equipped for instruction in anatomy, chemistry, physiology, bacteriology and other areas of learning necessary to the due course of study prescribed by these rules; and that a laboratory equipped with supplies, models, manikins, charts, stereopticon, roentgen-ray and other special apparatus used in teaching the system to treat human ailments without the use of medicine and operative surgery, be provided.

(f) That a working library, easily accessible to students, is maintained from at least 9 a.m. to 5 p.m., with a librarian in constant attendance. The library shall contain a standard medical dictionary, the modern text and reference books, and the files of leading periodicals dealing with the particular system of treating human ailments without the use of medicine and operative surgery.

(g) That the college or institution requires all students to furnish, before matriculation, satisfactory proof of the preliminary education required by the Medical Practice Act.

(h) That full and complete records are kept showing the credentials for admission, attendance, grades and financial accounts of each student.

(i) That admission of transfer students will be limited to honorably dismissed students from another approved college or institution teaching the same system. The transcript of record obtained directly from the transferring school shall be kept on file. It shall be the duty of a college or institution to furnish such a transcript for the benefit of each student subject to honorable dismissal. No credit shall be given a transferred student for final or "senior year" work or for any courses taken by correspondence.

(j) That students shall start class attendance within one week of the start of each session. That credit for completion of a course will not be granted a student who failed to attend 80 per cent of the complete session of the course.

RULE III—HOSPITALS APPROVED FOR INTERNSHIP.

1. A hospital shall, in the judgment of the Department, be deemed reputable and in good standing for training interns and intern services when it meets the following standards:

(a) General hospital of 150 beds' capacity, with an average of at least 60 patients daily, with rotating service.

(b) Shall contain at least the departments of

internal medicine, surgery, obstetrics and pediatrics; and an organized departmentalized staff, holding meetings monthly for case reviews and study.

(c) Laboratory employing a full-time qualified technician and at least a part-time qualified pathologist, visiting the laboratory at least two days per week.

(d) Radiological department employing a qualified X-ray technician and at least a part-time qualified roentgenologist, visiting the department at least two days per week.

(e) Maintenance of an up-to-date medical library located in a suitable study room available to interns.

(f) Such hospital shall provide and furnish the Department with the names of staff members of the various departments of the hospital.

(g) The hospital, upon the completion of a course of training therein of not less than twelve months, shall issue its certificate therefor to any such intern or at the request of the Department, such certificate shall include therein, by date, the commencement and the conclusion thereof.

2. An approved internship shall consist of twelve months rotating service in medicine, surgery, obstetrics and pediatrics, with an election in medical specialties.

In the event an applicant has received training in excess of the twelve months' period specified by the Medical Practice Act, and if this be in an institution approved by the Department as adequate for specialty training; and if the applicant has received certification by a recognized Medical Specialty Board, and has had two or more years' specialty practice or Military Service; such training and practice may be accepted as the equivalent of a rotating internship.

Any applicant who shall have completed twelve months of clinical training in a hospital, as required by Section 5-1(b) of the Medical Practice Act, and who has been accepted for further training in a specialty or general practice residency program by a hospital or institution approved by the Department for that purpose, shall be deemed to have complied with the requirements of this rule and of the Medical Practice Act in this regard.

Rule IV—Application for Examination

An applicant for examination for licensure to practice medicine in all of its branches, or any system of treating human ailments without the use of drugs or medicine and without operative surgery, must make application on forms furnished by the Department at least fifteen days prior to the examination and present, in addition:

(a) Recommendations from two (2) physicians duly licensed to practice in some state in the United States.

(b) A recent photograph, passport size, signed by applicant and two persons licensed to practice the system of treatment of human ailments for which the applicant is seeking a license. A duplicate photograph must be presented with the card of admission at the examination.

(c) The original diploma of graduation from the professional college in which the applicant completed his course of training, or, in lieu of presenting the diploma with the application, the applicant may present it at the examination.

(d) A certified copy of secondary school and professional school studies to be mailed direct to the Department by the schools attended or by the professional schools where the applicant completed the required course of study.

(e) Proof of completion of a rotating internship of twelve months in an approved hospital for applicants seeking admission to examination for license to practice medicine in all of its branches; and, in the case of graduates of medical colleges in countries other than the United States and Canada, who apply for examination after January 1, 1953, proof of rotating internships of one year in approved hospitals in the United States.

A candidate under Section 5, paragraph 1-b, or Section 13, may apply for the examination or clinical test and take the examination given immediately prior to completion of his internship provided he furnishes a statement from the hospital authorities stating his internship has been satisfactory to date. The results of the examination will be withheld and no license will be issued until the Department receives proof of satisfactory completion of the required internship in an approved hospital training program.

(f) Applicants who completed their medical courses in the extramural colleges of Ireland and Scotland shall not be eligible for admission to examinations for licensure under the Illinois Medical Practice Act.

(g) Graduates of European medical colleges or universities after January 1, 1943, with the exception of certain approved colleges in the British Isles, Denmark, Holland, Norway, Sweden and Switzerland, be not accepted for admission to examinations for licensure under the Illinois Medical Practice Act.

Graduates of such European medical colleges after January 1, 1943 may be considered for admission to Illinois examinations provided they present diplomas of graduation from approved medical colleges in the United States after attendance in such colleges for at least one year; and in addition, have served rotating internships of one year in approved hospitals

in the United States.

(h) An applicant who presented a diploma of graduation from an approved school will not be accepted, if he was accorded advanced standing in such school based upon his prior education in an unapproved school.

RULE V—EXAMINATIONS

1. Examinations for licensure to practice medicine in all of its branches shall be conducted in the English language and shall be in the following theoretical and practical areas of medicine:

THEORETICAL

Chemistry, Physiology, Anatomy, Pharmacology, Pathology, Bacteriology, Medicine, Public Health & Preventive Medicine, Obstetrics & Gynecology, Surgery, Pediatrics, Psychiatry

CLINICAL

General Practice of Medicine

2. Examinations for licensure to practice the treatment of human ailments without the use of drugs or medicine and without operative surgery shall be conducted in the English language and shall be in the following theoretical and practical subjects:

THEORETICAL

Chemistry & Physiology, Anatomy & Histology, Pathology & Bacteriology, Diagnosis, Hygiene & Medical Jurisprudence, Eye, Ear, Nose, & Throat, Dermatology, Pediatrics & Neurology, System of Practice, Obstetrics (for graduates of approved osteopathic colleges)

PRACTICAL

System of Practice

3. To be successful, applicants must receive general averages of 75% with no grade below 60% in the written examination, and a general average of 75% in the clinical or practical test.

Applicants applying for registration under Sections 12 and 12a of the Medical Practice Act shall be required to make general averages of 75% in the three subjects required for license to practice medicine and surgery in Illinois.

4. In case of failure in the first and second examinations applicants will be allowed credit on the following examination for all grades of 75% or more; but in case of failure in the third examination they must retake all written subjects at each subsequent examination. It is not required that the clinical or practical part of the examination be repeated after a passing grade of 75% has been received in that part of the examination.

5. Applicants who take the regular written examination conducted by the Department for licenses as Physicians and Surgeons shall be excused from taking the clinical test.

6. An applicant for registration as Physician and Surgeon who has been unsuccessful in five examinations will be deemed to be eligible for further examination upon receipt of proof that he has completed one year of residency training in an approved hospital training program in the United States received subsequent to the applicant's fifth failure.

7. An applicant who has been unsuccessful in five examinations for registration as a drugless practitioner will be eligible for reexamination upon receipt of proof that he has completed a course of study of 960 hours in a school which is accredited under the Medical Practice Act. This course must be received subsequent to the applicant's fifth failure.

8. An applicant who furnished proof of a course of study of 240 hours in a school of chiropractic recognized by the Department in order to be eligible for further examination under Section 9a of the Medical Practice Act will be considered as a new applicant and his grades of 75 per cent or more will be carried over to the second and third examinations.

RULE VI—RECIPROCITY

1. Each applicant for registration through reciprocity, either for the practice of medicine in all of its branches or for the treatment of human ailments without the use of drugs or medicine and without operative surgery, filed on forms provided by the Department, will be considered on its individual merits, provided the state or territory of original licensure grants a like privilege to persons licensed in Illinois.

2. If the application is not endorsed by officers of a state or county society it must be endorsed by two (2) physicians duly licensed to practice in some state in the United States.

3. Applicants for licensure through reciprocity or upon the basis of having passed the National Board Examination prior to January 1, 1964, must pass the clinical test conducted by this Department. Applicants upon the basis of the National Board Examination who completed Part III after January 1, 1964, are required to report for an interview with the Medical Examining Committee. The clinical test shall be such in the judgment of the Committee as will determine the qualifications of the applicant to practice medicine in all of its branches, taking into consideration the quality of medical education and clinical training or practical experience which the applicant has had, special honors or awards, publications in recognized and reputable journals, authorship of textbooks in medicine, and any other circumstance or attribute that the Committee accepts as evidence of an outstanding and proven ability in any branch of the field of medicine.

4. Graduates of Chiropractic colleges whose applications for registration in Illinois by reciprocity are approved, shall be required to pass a written

examination in theory in addition to a practical test before the chiropractic examiner.

Rule VII—Licensure

1. An examinate who successfully completes his medical examination must secure his certificate of licensure within one year from the date of his examination.

2. The Department will not issue a duplicate certificate of registration to practice medicine in all of its branches, or to treat human ailments without the use of drugs or medicine and without operative surgery, unless proof satisfactory to the Department and the Committee is presented that the original certificate was destroyed; or in case of change of name when the original certificate is returned for cancellation, together with satisfactory legal proof of such change of name.

3. A license to practice medicine in Illinois shall be a requisite for a residency in an Illinois hospital.

Rule VIII—Temporary Certificates of Registration

1. Any person not licensed to practice medicine in all of its branches in the State of Illinois who wishes to pursue a program of graduate or specialty or residency training in this State, must be the holder of a Temporary Certificate of Registration issued by the Department under the provisions of Section 11a of the Medical Practice Act of Illinois and in accordance with the provisions of the within Rules.

2. Application for a Temporary Certificate must be made on blank forms prepared and furnished by the Department. It must be submitted to the Department together with evidence satisfactory to the Department that applicant meets the requirements of Section 11a of the Illinois Medical Practice Act and that if his application is approved he will be accepted or appointed for the residency training in the hospital designated in such application.

3. A Temporary Certificate of Registration will be issued on behalf of an otherwise qualified applicant only for residency or specialty training in a hospital situated in this State which is approved by the Department for the purpose of such training. An approved hospital is one which in the judgment of the Department is qualified to offer such training, and which shall comply with the within Rules.

4. Written notice of the Department's final action on every application for a Temporary Certificate of Registration shall be given to the applicant and the hospital designated therein; when such application is approved the Temporary Certificate of Registration shall be delivered or mailed to the hospital designated therein and shall be kept in the care and custody of such hospital. The applicant shall not commence such specialty or residency training before he or the hospital receives written notification of approval of his application.

5. A Temporary Certificate of Registration shall not be valid for longer than one year after issuance thereof and may be renewed from time to time, in the discretion of the Department, for a period of not more than one year each time. Application for renewal must be made on forms prepared and furnished by the Department and the Temporary Certificate of Registration sought to be renewed must be submitted therewith to the Department.

6. When any person in whose behalf a Temporary Certificate of Registration has been issued shall be discharged or shall terminate his specialty or residency training in the hospital designated therein, such hospital shall immediately deliver or mail by registered mail to the Department his Temporary Certificate of Registration and written notice of the reason for return of same.

7. A Temporary Certificate of Registration is not transferable without prior notice to and approval by the Department. If the holder of a Temporary Certificate of Registration wishes to change to another training program in the approved hospital designated therein, or he wishes to enter a training program in another approved hospital, he must make application on Forms furnished by the Department. His current Temporary Certificate of Registration must accompany such application and he cannot thereafter continue in the training program designated on such current Certificate, and he may not commence such other training program until a Temporary Certificate of Registration has been issued therefor.

8. Not more than one Temporary Certificate of Registration shall be issued to any person for the same period of time. A person on whose behalf a Temporary Certificate of Registration has been issued is limited in the practice of medicine to the performing of such acts as may be prescribed by and incidental to his program of residency training in the hospital designated in his Temporary Certificate of Registration, and he cannot otherwise engage in the practice of medicine in the State of Illinois.

9. Whenever, under the within Rules, a hospital is required to deliver or return a Temporary Certificate of Registration to the Department, in case, because of the loss or destruction of such Certificate, or for any other reason, such hospital shall be unable immediately so to deliver or mail such Certificate, such hospital shall immediately mail or deliver to the Department a written explanation in detail of such inability.

10. The holder of a Temporary Certificate of Registration is not barred thereby from becoming eligible for admission to the Department examina-

tion for a license to practice medicine in Illinois if he otherwise meets the requirements for admission to such examination and if such person should fail to pass such examination such failure shall not bar him from completing his training program.

RULE IX—LIMITED LICENSES TO PRACTICE IN STATE HOSPITALS

1. Each application made on forms provided by the Department will be considered on its own merits.

2. The State Hospital at which the applicant will practice under the supervision of a medical officer, shall signify to the Department that the hospital will appoint the applicant in the event he receives a Limited License.

3. Any applicant for a Limited License who has failed in more than three examinations for licensure under the Illinois Medical Practice Act shall not be eligible for a Limited License.

4. State hospital permits of physicians not otherwise licensed to practice may be renewed only once after July 1, 1975, for a one year period, with all original permits and renewals to expire on July 1 after issuance. After July 1, 1975, all permit holders seeking renewal will be required to pass new examination given by Department of Registration and Education, or an equivalent examination.

ECFMG REQUIREMENTS

The Education Council for Foreign Medical Graduates (ECFMG) commenced operations in October, 1957. Sponsors of this agency are the American Hospital Association, American Medical Association, Association of American Medical Colleges, and Federation of State Medical Boards of the United States. ECFMG gives two examinations a year to foreign medical graduates. The examinations test the graduate's general knowledge of medicine and command of English.

Persons successfully passing this examination are granted an ECFMG certificate. This certificate in the State of Illinois is **not a substitute** for nor is it the equivalent of licensure to practice medicine. It simply indicates that the holder's command of English has been tested and found adequate for assuming an internship in an American hospital. The holder of such a certificate may not practice medicine in any degree in a hospital in Illinois unless he is within one of the categories outlined above.

Offenses Listed

An unlicensed person who commits any of the following acts regardless of whether the same be committed within or without a hospital is guilty of practicing medicine without a license—a criminal offense:

1. Hold himself out to the public as being engaged in the diagnosis or treatment of ailments of human beings.
2. Suggest, recommend or prescribe any form of treatment for the palliation, relief or cure of any physical or mental ailment of a person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatsoever.
3. Diagnosticate or attempt to diagnosticate any ailment or supposed ailment of another.
4. Operate upon, profess to heal, prescribe for, or otherwise treat any ailment, or supposed ailment of another.
5. Maintain an office for examination or treatment of persons afflicted, or alleged or supposed to be afflicted, by any ailment.
6. Attach the title Doctor, Physician, Surgeon, M.D., or any other word or abbreviation to his name, indicative that he is engaged in the treatment of human ailments as a business.

(*Medical Practice Act.* [Chp. 91, Sec. 16i, Paragraph 24, *1973 Rev. Stat.*])

Manifestly, the enforcement of the Medical Practice Act with respect to the elimination of unlicensed persons practicing medicine in a hospital is dependent upon co-operation by responsible persons within the hospital. It should be noted that lack of co-operation or failure to meet responsibilities can in a proper case be translated into criminal liability and disciplinary action resulting in revocation or suspenson of a license to practice medicine as follows:

1. The unlicensed person practicing medicine is committing a criminal offense.
2. A hospital administrator who assigns an unlicensed person to duties which involve his practicing medicine may subject himself to the criminal offense of aiding and abetting such unlicensed person to illegally practice medicine, and the same may be true of a hospital chief of staff or department head if in the nature of his duties he is directly responsible for assigning such duties to the unlicensed person.
3. A licensed doctor may have his license suspended or revoked if he has professional connection or association with another who is illegally practicing medicine. A chief of staff who knowingly allows such person to illegally practice medicine, or in a proper case, any member of the medical staff of a hospital may subject himself to disciplinary action against his license.
4. A licensed doctor may have his license suspended or revoked for unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public.

A member of the medical staff of a hospital may place himself within such conduct if he neglects, fails or refuses to fulfill his responsibilities while on emergency room call.

Physician's Assistants Act

Section 1. The purpose and legislative intent of this Act is to encourage and promote the more effective utilization of the skills of physicians by enabling them to delegate certain health tasks to physician's assistants where such delegation is consistent with the health and welfare of the patient and is conducted at the direction of and under the responsible supervision of the physician.

Section 2. This Act shall be known and may be cited as the "Physician's Assistants Practice Act."

Section 3. "Physician's assistant" means any person not a physician who is certified to perform medical procedures under the supervision of persons licensed to practice under "The Medical Practice Act." A physician's assistant may perform such medical procedures within the specialty of the supervising physician, except that such physician shall exercise such direction, supervision and control over such physician's assistants as will assure that patients receiving medical care from a physician's assistant shall receive medical care of the highest quality. Physician's assistants shall be capable of performing a variety of tasks within the specialty of medical care under the supervision of a physician, although the physician's assistant does not possess the level of medical knowledge necessary to integrate and interpret findings. Physician's assistants cannot exercise independent judgment for purposes of diagnosis and treatment of patients. Nothing in this Act shall be construed as relieving any physician of the professional or legal responsibility for the care and treatment of persons attended by himself or by physician's assistants under his supervision. Physician's assistants shall have only those powers and rights set forth in this Act and the exercise of any powers beyond those set forth shall constitute a violation of this Act.

Section 4. No physician's assistant shall use the title of doctor or associate with his name any other term which would indicate to other persons that he is qualified to engage in the general practice of medicine. A physician's assistant shall not be allowed to bill patients or in any way to charge for services. Nothing in this Act, however, shall be so construed as to prevent the employer of a physician's assistant from charging for services rendered by the physician's assistant. The physician shall file with the Department notice of employment and discharge of the physician's assistant at the time of said employment or discharge.

Section 5. No more than one physician's assistant shall be employed by a physician. Physician's assistants shall be employed only under the supervision of persons licensed to practice under "The Medical Practice Act" and engaged in private clinical practice, or in clinical practice in public health or other community health facilities.

Section 6. Each applicant for a physician's assistant certificate shall:

1. Make application for examination on forms prepared and furnished by the Department of Registration and Education.

2. Submit evidence under oath satisfactory to the Department that:

(a) He is 21 years of age or over;
(b) He is of good moral character;
(c) He has the preliminary and professional education required by this Act;
(d) He is free of contagious diseases.

3. Designate specifically the name, location, and kind of professional schools, colleges, or institutions attended and the courses which he has satisfactorily completed.

4. Pay to the Department of Registration and Education at the time of application, an examination fee of $25. The fee for subsequent renewal of a certificate without lapse shall be $15.

Section 7. Except as otherwise provided in this Act, the minimum standards of educational requirements prior to the taking of an examination shall consist of the following:

(a) Successful completion of a 4 year course of instruction in a high school, or its equivalent, as determined by the examining committee; and

(b) Successful completion of a specialized course for physician's assistants consisting of not less than 20 months instruction in any 2 year period; such course and the institution or school offering the same shall be approved by the examining committee provided for in this Act.

The examining committee shall have the power to waive the specialized training provided for in this Section, if the committee determines that any prior training and experience of the applicant is the equivalent of such specialized training.

Section 8. Registered nurses in the State of Illinois may take such examination without completing any additional courses of study and shall be issued a certificate upon the passage of such examination.

Section 9. Subject to the provisions of this Act, the Department of Registration and Education shall:

1. Promulgate rules approved by the examining committee setting forth standards to be met by a school or institution offering a course of training for physician's assistants prior to approval of such school or institution.

2. Promulgate rules approved by the examining committee setting forth uniform and reasonable standards of instruction, including but not limited to specific subjects taught, to be met prior to approval of such course of instruction for physician's assistants.

3. Determine the reputability and good standing of such schools or institutions and their course of instruction for physician's assistants by reference to compliance with such rules, provided that no school of physician's assistants that refuses admittance to applicants solely on account of race, color, sex, or creed shall be considered reputable and in good standing.

4. Prescribe rules for examining candidates for a certificate as physician's assistant.

5. All examinations provided for by this Act shall be conducted under rules and regulations prescribed

by the Department of Registration and Education. Examinations shall be held at least 3 times a year at times and places to be determined by the Department.

No rule or regulation shall be adopted under this Act which allows a physician's assistant to perform any act, task or function primarily performed in the lawful practice of optometry under "The Illinois Optometric Practice Act," approved June 15, 1951, as amended.

Section 10. Upon the satisfactory completion of application and examination procedures and compliance with the applicable rules and regulations of the Department of Registration and Education, the Department shall issue a physician's assistant certificate to the qualifying applicant.

Section 11 The Medical Examining Committee of the Department of Registration and Education as provided in Section 60-a of "The Civil Administrative Code of Illinois," approved March 17, 1917, as amended, may revoke or withdraw the certificate issued under this Act upon any of the following grounds:

1. Conviction in this or another state of any crime which is a felony under the law of this State, or conviction of a felony in a federal court;

2. Gross malpractice resulting in permanent injury or death of a patient;

3. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public;

4. Habitual intemperance in the use of alcohol, narcotics or stimulants to such an extent as to incapacitate for performance of professional duties.

5. Employment of fraud, deception or any unlawful means in applying for or securing a certificate as a physician's assistant;

6. Exceeding the authority delegated to him by his employing physician;

7. A violation of any provisions of this Act or of the rules and regulations formulated for its administration.

Section 12. No action of a disciplinary nature which is predicated on charges alleging unethical or unprofessional conduct of a person who practices as a physician's assistant and which can be reasonably expected to affect adversely that person's maintenance of his present, or his securing of future, employment as such a physician's assistant may be taken by the Department of Registration and Education, by any association, or by any person unless the physician's assistant against whom such charges are made is afforded the right to be represented by legal counsel of his choosing and to present any witness, whether an attorney or otherwise, to testify on matters relevant to such charges.

Section 13. Certificates may be revoked or suspended only in the manner provided by Section 60b through 60h inclusive of "The Civil Administrative Code of Illinois," approved March 7, 1917, as now or hereafter amended.

Section 14. All final administrative decisions of the Department of Registration and Education are subject to judicial review pursuant to the provisions of the "Administrative Review Act," approved May 8, 1945, and all amendments and modifications thereof, and the rules adopted pursuant thereto. The term "administrative decision" is defined in Section 1 of the "Administrative Review Act."

Section 15. All certificates issued under this Act must be renewed every 2 years after their issuance and the examining committee may require a physician's assistant to submit to a mental or physical examination at any time felt necessary by the examining committee.

Section 16. No person shall use the title or perform the duties of "physician's assistant" unless he is a qualified holder of a certificate as provided in this Act. A certified physician's assistant shall wear on his person a visible identication indicating that he is certified as a physician's assistant while acting in the course of his duties.

Section 17. The Medical Examining Committee of the Department of Registration and Education shall review the provisions of this Act to determine its effectiveness and accomplishments and shall solicit the cooperation and advice of such public and private agencies as the Committee may deem proper. The Committee shall report its findings and recommendations to the Governor and the General Assmbly on January 1, 1980.

Section 18. This Act takes effect July 1, 1976.

Section 19. This Act is repealed on June 30, 1981.

Other Examining Boards

Other examining boards operating under the jurisdiction of the Department of Registration and Education are:

Dental Examining Committee
William T. Osmanski, D.D.S.
Lawrence Ginestra
Silas P. Jones, D.D.S.
Richard A. Kozal, D.D.S.
Ogden Munroe, D.D.S.
Kermit C. Miller, D.D.S.
George P. Shevlin, D.D.S.

Committee of Nurse Examiners
Mary Ann Santucci
Charlotte P. Anders
Maxine Brower
Joyce Griffin
Margaret J. Stafford
Christopher Hannan
Mary Kachoyeanos
James Larabee
Juanita Stewart

Nursing Home Administrator Examining Committee
Stephen Groszos
Daniel Halpern
Caroline Redebaugh
John Chapman
Bertram Moss
Two vacancies

Illinois Optometric Examining Committee
Robert W. Stoelzle, O.D.
Henry R. Moore, O.D.
Frank F. Sakamoto, O.D.
Richard L. Stratton, O.D.
Floyd Woods, O.D.

State Pharmacy Board
Milton G. Christy
Henry Cade
Raymond Haraburda
Eugene F. Kaelin
Clarence Charles Lev
Philip Sacks
Prof. Martin I. Blake

Physical Therapy Examining Committee
Vilma I. Evans
Mary Liedloff
Eugene J. Rogers, M.D.
John J. Mustari
Frank Tremaroli

Podiatry Examining Committee
Lowell S. Weil
Seymour Kessler
Joseph B. Rubino, DPM

Psychologist Examining Committee
Dr. Frank Kobler
Dr. Morris Aderman
Dr. Frank Costin
Dorothy Jean Dettmar
Johanna Krout Tabin

DIVISION OF VOCATIONAL REHABILITATION

623 East Adams Street
Springfield, IL. 62706
Eugene P. Turner, *Director*

The Board of Vocational Education and Rehabilitation is a statutory body, established to administer, through two operating divisions, the state program of vocational and technical education pursuant to the Federal Vocational Education Act, as amended, and the state program of vocational rehabilitation pursuant to the Federal Vocational Rehabilitation Act as amended.

Board of Vocational Education and Rehabilitation

Statutory Members:

Mary Lee Leahy, Director
Department of Children & Family Services
Suite 1713, 160 N. LaSalle St., Chicago 60601

Robert J. Williams, Director
Department of Agriculture
Junior Livestock Bldg., State Fairgrounds
Springfield 62706

Kenneth W. Holland, Director
Department of Labor
704 State Office Building, Springfield 62706

LeRoy P. Levitt, M.D., Director
Department of Mental Health
Rm. 1500, 160 N. LaSalle St., Chicago 60601

Joseph Cronin, Director
Illinois Office of Education
307 State Office Building, Springfield 62706

Joyce C. Lashof, M.D., Director
Department of Public Health
535 W. Jefferson Street, Springfield 62706

Ronald Stackler, Director
Department of Registration & Education
628 E. Adams Street, Springfield 62706

Lay Members:

Chairman of the Board:

Dorothy Grant Arndt
1330 26th Avenue, Rock Island 61201

Frank C. Bacon, Jr.
Sears Bldg., 403 South State Street, Chicago 60605

Harold Byers
2218 Park Hill Drive, Highland 62249

Mary E. McKean
447 Arlington, Elmhurst 60126

Emmett Palmer
6 N. 431 Gary Avenue, Keeneyville

Tony Vasquez
2645 South Christiana, Chicago 60623

ILLINOIS REGIONAL MEDICAL PROGRAM
REGIONAL ADVISORY GROUP

The Illinois Regional Medical Program, which began in 1967, is a federally funded but autonomous organization charged with improving the health care of the citizens of the state of Illinois. The program goals objectives are a single standard of high quality health care, provided with maximum effectiveness at minimal cost, and accessible to all. The IRMP helps reach those goals by supporting and engaging in activities aimed at fulfilling the following health care objectives: 1) improved understanding of health and health care (public education); 2) optimum deployment of entry points to the health care system (primary care); 3) optimum relationship of the components of the health care system to each other (regionalization); 4) optimum availability of human and technical resources for the health care system (manpower and technology); and 5) assurance and maintenance of

high quality care. The Regional Advisory Group, the policy-making body of the IRMP, must approve all project applications for funding. The RAG is composed of representatives from the medical profession, allied health professions, hospital administration, planning agencies, voluntary and official health groups, medical schools and teaching hospitals in the state, as well as members of the general public familiar with the financing of, and the need for, health care.

Regional Advisory Group

Dexter Nelson, M.D., Princeton, *Chairman*
Leonidas H. Berry, M.D., Chicago
Daniel K. Bloomfield, M.D., Urbana
Josephine Brandt, R.N., Moline
Andrew Brislen, M.D., Chicago
Edgar Britton, Chicago
Murray C. Brown, M.D., Chicago
Donald J. Caseley, M.D., Chicago
Jacob Cates, Belvidere
Donald P. Colleton, Chicago
Effie O. Ellis, M.D., Chicago
Vilma Evans, R.P.T., Danville
Stanley Goldstein, M.D., Decatur
Charles R. Goulet, Chicago
Arthur L. Grist, Edwardsville
William J. Grove, M.D., Chicago
Emanuel Hallowitz, Chicago
William Hejna, M.D., Chicago
Irwin M. Jarett, Ph.D., Springfield
Sister Clementia Jerome, A.S.C., Taylorville
Allen Kelly, Eldorado
Richard H. Kessler, M.D., Chicago
Robert A. Kistner, D.O., M.D., Chicago
Marion Lamet, Warsaw
Joyce C. Lashof, M.D., Springfield
August P. Lemberger, Ph.D., Chicago
Mark H. Lepper, M.D., Chicago
LeRoy P. Levitt, M.D., Chicago
Henry J. Luckhardt, O.D., Westmont
Harold W. Maysent, Rockford
Frances McCann, R.N., M.Ed., River Grove
George M. O'Neill, Carbondale
Robert J. Parker, M.D., Bloomington
Caesar Portes, M.D., Chicago
Morris Profitt, M.D., Chicago
Paul Racqkiewicz, Granite City
Will Rasmussen, Chicago
Barbara Rohrer, Peoria
Edward F. Scanlon, M.D., Evanston
Maynard Shapiro, M.D., Chicago
Hiram Sibley, Chicago
Weathers Y. Sykes, Chicago
A. Nichols Taylor, Ph.D., Chicago
John C. Troxel, M.D., Chicago
Sheldon Wallach, D.D.S., Glenwood
J. A. Wells, M.D., Maywood
Perry Whiteside, Chicago

Medical Legal Information

(Prepared by ISMS Legal Counsel)

The purpose of this article is to present the Illinois medical community with a general view of certain medical-legal principles and relationships which many physicians may encounter in the ordinary practice of their profession. Because this article is intended to provide information of a general nature only, specific problems should be discussed with one's individual attorney. While this presentation is not all-inclusive, it will afford an insight into the more common considerations.

ISMS LEGAL SERVICES

The Illinois State Medical Society retains, on a continuing basis, a general counsel to whom the Society refers legal questions affecting the membership as a whole. ISMS also answers specific inquiries made by the component county medical societies when they are of general interest to the medical community. Although the Illinois State Medical Society cannot provide peronal legal advice to individual members, the Society does believe the following information will help further each physician's awareness of certain basic legal principles and concepts vital to his practice.

THE PHYSICIAN-PATIENT RELATIONSHIP

Contractual Relationship

In most instances the physician-patient relationship is a voluntary, contractual one. Accordingly, physicians are required to accept only those patients they elect to treat. The professional services rendered on behalf of particular patients and the fees compensating the physician for those services are to be decided by the physician and the patient.

Whenever possible, the physician should discuss his fee with the patient in advance of treatment. If feasible, the understanding as to the fee should be reduced to writing as a permanent record for both parties. Not only does such a procedure minimize misunderstanding, but it may help to re-emphasize to the patient, and his carrier, the specific contractual duties that the patient has undertaken. In the absence of a specific fee agreement, a physician is entitled to "reasonable compensation" for services rendered by him.

While, as has been indicated above, a physician is free to determine who will be his patients, once the physician has undertaken the treatment of a particular patient, he is under a legal duty, subject to certain exceptions discussed below, to continue his attendance so long as the case requires attention. To disregard this duty may constitute negligence or malpractice on the part of the physician.

A physician may legally terminate his attendance of a particular case in several ways:

1. The contract between the physician and the patient expressly limits the scope of treatment;
2. The patient may discharge the physician;
3. The relationship may end by mutual consent;
4. The physician may legally terminate his services if the patient breaks the contract by failing to observe the medical directives of the physician.

In the event the patient fails to follow the physician's advice, the duties of the attending physician do not immediately terminate. Rather, the attending physician must provide the patient with sufficient, reasonable notice of his intention to withdraw, so as to enable the patient to secure another physician. This notice should be in writing and briefly explain to the patient the reason for the intended termination. If the patient returns to the attending physician, and has been unable to procure other medical assistance, the attending physician should *not* refuse continued treatment until a replacement has been secured.

HOSPITAL PATIENT RECORDS

Illinois law provides that every public and private hospital in the State shall, upon the written demand of any discharged patient, permit that patient's physician or authorized attorney to examine and make copies of his hospital records. These disclosure provisions do *not* apply in the case of a psychiatrist-patient relationship.

NEGLIGENCE LIABILITY OF PHYSICIANS

Illinois law requires physicians and surgeons to exercise that degree of reasonable skill as is used in ordinary good practice. The failure to exercise such skill will result in liability if the patient is thereby injured.

Recently, there has been a tendency (especially in the larger cities) to expand liability and to increase the amounts of recovery once liability has been established. When a sympathetic jury views an injured patient, it may well be inclined to interpret the facts in a manner detrimental to the physician. Although the "reasonable skill" standard is not unduly harsh, it is flexible enough to make its application in a particular lawsuit quite subjective.

While the legal implications in the field of malpractice litigation are numerous in scope, basically, the physician is liable for his own negligent acts and the negligent acts of all his employees. In the case of a partnership, he is also liable for the negligent acts of his partners.

Today there is simply no existing alternative to carrying adequate liability insurance. While the cost of various types of malpractice insurance coverage is costly and still increasing, it is nonetheless recommended that extremely high limits be maintained in one's policy.

In addition to purchase of malpractice insurance, each physician should attempt to conduct his practice in such a fashion that the initiation of (and the finding of "guilty" verdicts in) malpractice litigation is greatly minimized.

The American Medical Association has published and prepared for distribution a pamphlet entitled "Professional Liability and the Physician." Twenty guidelines for preventing malpractice actions are set forth in that pamphlet:

1. The physician must care for every patient with scrupulous attention given to the requirements of good medical practice.
2. The physician must know and exercise his legal duty to the patient.
3. The physician must avoid destructive and unethical criticism of the work of other physicians.
4. The physician must keep records which clearly show what was done and when it was done, which clearly indicate that nothing was neglected, and which demonstrate that the care given met fully the standards demanded by the law. If any patient discontinues treatment before he should, or fails to follow instructions, the records should show it; a good method is to preserve a carbon copy of the physician's letter advising the patient against the unwise course.
5. A physician must avoid making any statement which constitutes, or might be construed as constituting, an admission of fault on his part. He should instruct employees to make no such statements.
6. The physician must exercise tact as well as professional ability in handling his patients, and should insist on a professional consultation if the patient is not doing well, if the patient is unhappy and complaining, or if the family's attitude indicates dissatisfaction.
7. The physician must refrain from over-optimistic prognoses.
8. The physician must advise his patients of any intended absences from practice and recommend, or make available, a qualified substitute. The patient must not be abandoned.
9. The physician must unfailingly secure an "informed" consent (preferably in writing) for medical and surgical procedures and for autopsy.
10. The physician must carefully select and supervise assistants and employees and take great care in delegating duties to them.
11. The physician should limit his practice to those fields which are well within his qualifications.
12. The physician must frequently check the condition of his equipment and make use of every available safety installation.
13. The physician should make every effort to reach an understanding with his patient in the matter of fees, preferably in advance of treatment
14. The physician must realize that it is dangerous to diagnose or prescribe by telephone.
15. The physician should not sterilize a patient solely for the patient's convenience, except after a reasonably complete explanation of the procedure and its risks and possible complications; and after obtaining a signed consent from the patient and from the patient's spouse, if the patient is married. Such sterilization is a crime in Connecticut, Kansas, and Utah and should not be performed in those states. Eugenic sterilization should be performed only in conformity with the law of the state, if any. Sterilization for therapeutic purposes may lawfully be performed with the informed consent of the patient and preferably with the informed consent of the patient's spouse, if the patient is married.
16. Except in an actual emergency situation which makes it impossible to avoid doing so, a male physician should not examine a female patient unless an assistant or nurse, or a member of the patient's family is present.

17. The physician should exhaust all reasonable methods of securing diagnosis before embarking upon a therapeutic course.

18. The physician should use conservative and less dangerous methods of diagnosis and treatment wherever possible, in preference to highly toxic agents or dangerous surgical procedures.

19. The physician should read the manufacturer's brochure accompanying a toxic agent to be used for diagnostic or therapeutic purposes and, in addition, should ascertain the customary dosage or usage in his area.

20. The physician should be aware of all the known toxic reactions to any drug he uses, together with the proper methods for treating such reactions.

In the October, 1971, issue of the *Illinois Medical Journal,* legal counsel to the Illinois State Medical Society expanded upon the recommendations of the AMA and urged that Illinois physicians also observe the following preventative safeguards:

1. Physicians should conduct their practice in hospitals so that they comply with, and live up to, the standards for hospital accreditation of the American Hospital Association, the hospital regulations adopted by the State Department of Public Health under the Hospital Licensing Act, and the by-laws of the hospital in which they are practicing.

2. Physicians should keep up on modern medicine in the fields in which they practice so they are conversant with and use the latest proven developments.

3. Physicians should call in specialists whenever the need arises.

4. Physicians should provide for automatic consultation in all serious cases—it cannot be disputed that any physician being called on to defend his treatment in court is in a much better position if he can also bring forth as a witness the physician who reviewed the case and consulted with him, or the specialist in a given field called in by him.

5. Hospital records and those of the physician should be kept in such manner and in such detail as will be meaningful and show that adequate medical procedures were followed. It should be remembered that cases frequently are not filed until some time after the alleged injury took place and sometimes do not come to trial for several years thereafter.

6. All cases should be treated in such a manner and records kept as if the case would result in a malpractice suit, and would not come to trial for a considerable period of time after the alleged injury had taken place.

7. Physicians should carry adequate malpractice insurance.

ILLINOIS CONTROLLED SUBSTANCES ACT

Under the Illinois Controlled Substances Act, physicians who dispense various controlled substances are required to register with the Illinois Department of Registration and Education. Categories of drugs under which registration is required are almost identical to those established by the Federal DEA.

LIMITS ON LIABILITY—SPECIAL SITUATIONS

Under the "Good Samaritan" amendment to the Medical Practice Act, physicians who, in good faith and without prior notice of the illness or injury, provide emergency care without fee to a person, shall not, as a result of acts or omissions, except wilful or wanton misconduct, be liable for civil damages.

The Medical Practice Act further provides that any physician, serving on any medical utilization committee, medical review committee, or peer review committee shall not be liable for civil damages as a result of his acts, or omissions, or decisions in connection with his duties on such committee, except those acts, omissions or decisions which involve wilful or wanton misconduct.

AUTOPSY

The *Illinois Revised Statutes* specifically detail the conditions under which a physician may perform an autopsy. Essentially, an autopsy may be performed provided:

1. The physician has a written authorization from the decedent to do so; or
2. The physician has a written authorization from a surviving relative who has the right to determine the method for disposing of the body or a next of kin or other person who has such right (a "surviving relative" means the spouse, an adult child, the parent, or an adult brother or sister of the decedent); or
3. The physician has a telegraphic or telephonic authorization from a surviving relative who has the right to determine the method for disposing of the body or a next of kin or other person who has such right. This last provision is conditioned, however, upon the requirement that the telegraphic or telephonic authorization is verified, in writing, by at least two persons who were present at the time and place the authorization was received.

Illinois law specifically provides that where two or more persons have equal right to determine the method for disposing of the body, the authorization of only one such person shall be necessary, unless, before the autopsy is performed, any others having such equal right shall object in writing or, if not physically present in the community where the autopsy is to be performed, by telephonic or telegraphic communication to the physician by whom the autopsy is to be performed.

While authorization may be given to a physician or hospital administrator or his duly authorized representative, only a physician shall perform the autopsy. The authorized personnel of a hospital or other qualified personnel selected by a physician may assist a physician performing an autopsy.

The term "written authorization", provided for above, means any printed, typed or handwritten communication signed by the person granting the authorization.

It is important to emphasize that, in Illinois, the heirs and next of kin can bring an action for mutiliation of the body of a decedent in those cases in which an autopsy is performed without authority or permission. In order to avoid the possibility of liability, autopsies should only be performed when ordered by the cororner or upon the appropriate written consent of the next of kin as specified above. (The cororner may order an autopsy directly against the wishes of the next of kin).

CONSENT OF MINORS TO MEDICAL TREATMENT

Birth Control Services for Minors: Birth control services and information may be rendered by doctors licensed in Illinois to practice medicine in all of its branches to any minor: who is married; who is a parent; who is pregnant; who has the consent of his parent or legal guardian; as to whom the failure to provide such services would create a serious health hazard; or who is referred for such services by a physician, clergyman or a planned parenthood agency.

Venereal Disease and Drug Use—Consent to Treatment By Minor: Illinois law specifically provides that a minor, 12 years of age or older, who may have come into contact with any venereal disease or who is suffering from the use of depressant or stimulant drugs or narcotic drugs (as defined in Controlled Substances Acts), may give his or her own binding consent, which is not later voidable, to the furnishing of medical care or counselling related to the diagnosis or treatment of such disease. Each incident of venereal disease shall be reported to the State Department of Public Health or the local board of health in accordance with regulations that may be so adopted. Illinois law specifically states that the consent of the parent, parents, or guardian of such minor, receiving such treatment or counselling, shall not be necessary to authorize the care or counselling which is related to the diagnosis or treatment of such disease or drug or narcotic use.

Any physician who provides diagnosis or treatment to a minor patient who has come into contact with any venereal disease or suffers from the use of any drug or narcotic, referred to above, may, but shall not be obligated to, inform the parent, parents or legal guardian of any such minor as to the treatment given or needed.

CATEGORIES OF MINORS WHO MAY, BY LAW, GIVE CONSENT TO ANY AND ALL MEDICAL TREATMENT

Parental Consent for Treatment of a Minor Child When Parent is Also a Minor: Illinois law provides that a parent who is a minor may give his or her consent to the performance upon his or her child of a medical or surgical procedure by a physician licensed to practice medicine and surgery or a dental procedure by a licensed dentist. The consent of such parent is not voidable because of his or her minority and Illinois law specifically provides that this parent, who is a minor, is deemed to have the same legal capacity to act and shall have the same powers and obligations as has a person of legal age.

"The consent to the performance of a medical or surgical procedure, by a physician licensed to practice medicine and surgery, which is executed by a married person who is a minor or by a pregnant woman who is a minor is not voidable because of such minority and Illinois law further provides that such married person, who is a minor, or such pregnant woman, who is a minor, is deemed to have the same legal capacity to act and has the same powers and obligations as has a person of legal age."

Situations Where Consent Need Not Be Obtained For Treatment of a Minor: Whenever a hospital or a physician renders emergency treatment or first aid (or a licensed dentist renders emergency dental treatment) to a minor, consent of the minor's parent or legal guardian need not be obtained if, in the sole opinion of the physician, dentist or hospital, the obtaining of consent is not reasonably feasible under the circumstances without adversely affecting the condition of such minor's health.

UNEMPLOYMENT COMPENSATION

The Illinois Unemployment Compensation law has recently been expanded so that it now includes coverage by physicians who employ only one person. This liability was discussed at some length in the "Practice Management" section of the July, 1973, issue of the *Illinois Medical Journal*. If physicians have specific questions regarding the applicability of unemployment compensation to their employees, they should consult the Illinois Department of Labor, Division of Unemployment Compensation, or their attorney.

BLOOD LABELING

The Illinois Blood Labeling Act contains three requirements of particular importance to the medical profession:

1. No person may administer blood by transfusion in Illinois unless the container of such blood is labeled in conformity with regulations developed and specified by the Illinois Department of Public Health;

2. When blood is administered by transfusion in Illinois, the identification number of the unit of blood must be recorded in the patient's medical record and the label on the container of blood may not be removed before or during the administration of that blood by transfusion;

3. As of July 1, 1973, no blood (which has been initially acquired by purchase) may be administered by transfusion in Illinois unless:

 a. The physician in charge of the treatment of the patient to whom the blood is to be administered has directed that such purchased blood be administered to that patient; and

 b. The physician in charge of the treatment of the patient has specified in the patient's medical record his reason for such action.

IMMUNIZATION

In 1972, legislation was passed to eliminate the requirement of smallpox immunization and to add rubella to the list of diseases against which there must be immunization.

The 1973 session of the Illinois General Assembly, however, eliminated a listing of specific diseases against which there must be immunization and transferred responsibility for determination of these to the Illinois Department of Public Health. Thus, the director will promulgate regulations, which may change from time to time, as to which diseases children will be immunized against. This affects the School Code and the Communicable Disease Act.

MEDICAL CORPORATIONS

Until 1963, when the Illinois General Assembly passed the Medical Corporation Act, physicians were not able to avail themselves of the legal advantages of doing business as a corporation. Historically, a primary reason for forbidding the use of the corporate form for doctors was that the personal assets of a corporation's stockholders were traditionally beyond the reach of creditors, including persons injured by the agents of the corporation. Because the public wished to insure itself of the best medical care, the law would not permit doctors to insulate themselves from personal malpractice liability.

The corporate form did, however, present certain advantages, particularly in the area of taxation, for which there was no compelling reason to discriminate against professionals. Throughout the past two decades the tax status of various professional medical corporations were thrashed out among the Internal Revenue Service, the Federal courts and professionals who claimed that their businesses were entitled to be taxed as corporations. Although many legal questions still remain unresolved, it is now reasonably certain that physicians in Illinois can take advantage of the corporate form.

Under the Illinois law, all the shareholders, officers and directors of a medical corporation must be licensed physicians. The corporation must register with the Illinois Department of Registration and Education under whose auspices it is permitted to operate. This law explicitly denies physicians working within a corporation the right to insulate their personal assets from malpractice liability.

Tax consequences are the primary factors in determining the wisdom of incorporation. In an article written for the November, 1970, issue of the *Illinois Bar Journal* Linscott R. Hanson summarized the advantages and disadvantages of incorporation. Among the major *advantages* listed, were:

1. Deductability by employees of a portion of their sick pay.
2. Deductability as a corporate business expense of the full cost of employee accident and health insurance.
3. Deductability as a corporate business expense of medical payments in excess of insurance.
4. Lower corporate tax rates for funds to be re-invested in the business.
5. Relatively easy adjustment of ownership percentages.
6. Avoidance of many probate problems upon the death of a practitioner and the avoidance of having to create a whole new business as when a partner dies.
7. Liability limitation, other than for malpractice, to the investment in the corporation thus reducing investors' risks.
8. Miscellaneous pension and profit-sharing tax advantages.

The disadvantages listed by Hanson included:

1. Possible legal costs in defending, to the Internal Revenue Service, the corporate status.
2. An increase of up to 25% for Social Security costs.
3. Corporate franchise taxes.
4. Possible subjection in fact to capital stock and personal property taxes.
5. Increased administrative and legal costs.
6. Increased state income tax payments.
7. State licensing fees.
8. Subjection to a host of State and Federal regulations of corporations.

Certainly each practitioner, physician and partnership should consider the merits of incorporating. The purpose here has been to give a brief explanation so that each interested physician can receive a general over-view of his options. A tax specialist should, of course, be consulted to review the particulars of each business situation.

MDs EXCLUDED FROM 'CERTIFICATE OF NEED' CONTROLS

Plans to build, expand, move or sell a hospital, nursing home or surgicenter require approval of the State Comprehensive Health Planning (CHP) Agency.

A provision in the original bill which would have brought physicians' offices and clinics under "certificate of need" regulation was withdrawn because of vigorous ISMS opposition.

This law covers construction or modification plans involving an expenditure of more than $100,000, or a substantial change in services or bed capacity. In effect, facilities covered by the "certificate of need" umbrella will be shifted into a semi-public utility status.

Local CHP agencies are to hold public hearings on all applications for construction or expansion of facilities before submitting a recommendation to the state CHP board for final action. The State CHP agency is required to study: (1) area size; (2) population and growth potential; (3) number of existing and planned facilities offering similar services; (4) utilization of existing facilities and (5) availability of alternative facilities and services before granting approval.

REGULATE HMO DEVELOPMENT, SERVICES

A nine-member Health Maintenance Advisory Board within the Illinois Department of Public Health (IDPH) will develop standards governing the quality of services provided by Health Maintenance Organizations (HMOs).

Under S.B. 1128, IDPH also will evaluate an HMO applicant's ability to meet these standards and refer its findings to the Illinois Department of Insurance which grants HMO certification. In addition, IDPH is required to conduct annual reviews of HMO services.

INSURANCE AND CLAIM FORMS

Various forms are used for submitting claims, either for reimbursement of the insured or on assignment. Generally speaking, these forms are related to the coverage purchased and the contract of the insured with a carrier. Physicians are cautioned to provide only such information as that to which they can personally attest, and that there is not granted a blanket authority for reimbursement of services performed by another professional when the physician has not personally seen the patient.

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Legislative Report

The first session of the Illinois General Assembly adjourned after considering a record 4,626 bills. Of that number, 498 were related in some way to health care. During the session, the ISMS position on legislation successfully prevailed 88% of the time. Ninety-six per cent of those bills which ISMS opposed were defeated, while 81% of those supported were passed. Major bills which passed are included in the analysis in this report.

Malpractice

In an attempt to avert a crisis situation as has crippled health care in other states, ISMS introduced a series of bills for reform of the Civil Practice Act as it applies to medical malpractice. Of these, **S.B. 1024** passed the legislature and was signed by Governor Walker on September 12th. The bill establishes medical review panels in each circuit court district to serve as the entry point for all malpractice claims. These panels—comprised of a physician, a lawyer, and a judge of the circuit court—are empowered to hear testimony and evidence, to subpoena witnesses or records as necessary, and to make determinations as to liability and amount of damages, if any. Decisions of the panel are binding upon the written acceptance of both parties. Rejection by either side sends the case to trial where the decision of the panel is inadmissible. The bill also modifies the statute of limitations to 2 years after discovery, but no more than 5 years after occurrence—except in the case of those under 18, the mentally ill, or those imprisoned on criminal charges, in which case the statute does not begin to apply until the qualifying condition is removed. Awards are limited to no more than $500,000, and insurance companies are prohibited from raising premiums without justification to, and the approval of, the Department of Insurance. Finally, any agreement or contract entered into prior to or as a condition for treatment which releases any provider from liability is declared to be void.

A second bill also signed by the Governor on September 12, **H.B. 1968,** provides for the establishment of joint underwriting authorities if professional liability insurance either becomes unavailable or if its cost becomes so high as to endanger the availability of quality health care to the people of the state.

Although passage of these bills is a first step towards solving the problem, this does not mark the end of ISMS's effort to deal with the professional liability crisis. The recently formed ISMS Task Force on Professional Liability, composed of representatives of ISMS, the Illinois Hospital Association, various specialty societies, Illinois Dental Society and other providers, has met and begun work on a new legislative package to be introduced when the legislative session reopens.

Medical Discipline/ Continuing Medical Education

Closely tied to the malpractice legislation were a number of proposals dealing with medical discipline and continuing medical education. Of this group, three bills—**H.B. 1964, 2692,** and **2693**—are of major importance.

Sponsored by Representative Harold Katz, **H.B. 1964** requires the Department of Registration and Education, through the Medical Examining Committee, to promulgate mandatory standards of continuing medical education as a requirement for reissuance of license. While not stipulating mechanics, the bill calls on the Department to recognize existing CME programs and to consider requirements of the specialties for board certification. It also mandates that programs be organized so they are easily accessible to all physicians, without requiring inordinate amounts of time away from their practices.

Recent discussions with Dr. Richardson, Chairman of the Medical Examining Committee, indicate that the feelings of the Committee towards the implementation of this program would be to follow the CME requirements of the specialty societies and of the AMA's Physicians Recognition Award Program. On September 16th, Governor Walker returned H.B. 1964 to the legislature with a recommendation for certain changes in wording which are considered to be of minor significance.

H.B.s 2692 and **2693** were drafted in response to criticism from the public at large that the medical profession does not adequately police itself—even though the law as it presently exists provides no mechanism for doing so. Many of the members of the legislature had expressed an interest in passing such legislation, but had provided a very limited role for physicians in the discipline process. These bills intend to use the

BILLS OF PRIMARY INTEREST TO ISMS
79th GENERAL ASSEMBLY

Bill	Synopsis	ISMS Position	Status
S.B. 27	Newborn Insurance	Support	Signed 6-27-75
S.B. 250	Allows chiropractors to do school physicals	Oppose	Defeated in Senate Insurance Committee
S.B. 254	Equates M.D.'s and chiropractors under Blue Shield	Oppose	Signed 8-29-75
S.B. 1024	Medical Malpractice	Support	Signed 9-12-75
S.B. 1059	Hospital Association's Rate Review Bill	Not Opposed	Defeated on floor of Senate
H.B. 11	Death With Dignity	Oppose	Defeated in House Human Resources Com.
H.B. 266	Criminal penalties for "On Call" M.D.'s not responding to emergency calls	Oppose	Tabled in House Human Resources Com.
H.B. 611	Eliminates 2½ year retention of original X-ray film	Support	Signed 8-14-75
H.B. 618	Death With Dignity	Oppose	Defeated on House Floor
H.B. 871	3 year trial program lab proficiency tests	Support	Signed 8-14-75
H.B. 1077 1078	Abolishes office of County Coroner— Establishes Medical Examiner System	Support	Defeated in House Counties & Townships
H.B. 1291	Creates the Nursing Board of Opinions	Support	Signed 9-4-75
H.B. 1964	Continuing Medical Education	Support as Amended	Return to legislature with recommendation for change 9-16-75
H.B. 2013 2054	State Council on Nutrition	Support	Passed House. Defeated on Senate Floor
H.B. 2245 2246	Repeal of Drug Antisubstitution Laws. Allows Generic Prescribing	Oppose	Interim Study Calendar
H.B. 2608	Allows nurses to diagnose illness	Oppose	Defeated in Senate
H.B. 2615	Allows chiropractors to perform acupuncture	Oppose	Defeated in House Human Resources Com.
H.B. 2692 2693	Medical Discipline Reform	Support	Passed House and Senate. To the Governor
H.B. 3038 3039	Family Practice Residency Program	Support	Passed House. Fall Calendar in Senate
H.B. 3048	Sets standards for school physical examinations	Support	Passed House. Fall Calendar in Senate
H.B. 3067	Dept. of Public Health's Hospital Rate Review	Oppose	Fall Calendar in House.

experience of the practicing physician in medical discipline, rather than relegating control of the process to bureaucrats and others who have no medical expertise. As of this writing H.B.s 2692 and 2693 were amendatorily vetoed by the Governor.

If overriden, these bills will establish 13 new grounds for disciplinary action, including abandonment of a patient, repeated acts of gross misconduct, professional or mental incomptence, and debilitating physical illness. The bills also provide for the establishment of a 7 member medical disciplinary board, independent of the Medical Examining Committee, which would be responsible for the investigation of alleged violation of the Medical Practice Act.

Medical-Legal Legislation

Under legislation passed during the last session, a number of medical legal questions have been given legal answers. Included in this category are the following:

H.B. 1369 defines death for the purposes of the Uniform Anatomical Gift Act, as the irreversible cessation of total brain function.

H.B. 2086 and **S.B. 1092** guarantee the confidentiality of mental health records maintained by the Department of Mental Health, by prohibiting the Department from using identifiable patient data in the development of its 5-year plan. On September 3rd, Governor Walker signed S.B. 1092, while vetoeing H.B. 2086.

S.B. 416 prohibits fee splitting between pharmacists and physicians, while exempting from the definition of fee splitting the payment of rent or utilities from a pharmacist to a physician. S.B. 416 was signed on August 27th.

S.B. 968 extends the liability exemption provisions of an Act Relating to the Use of Human Tissues until 1978. The Governor signed this bill on August 25th.

Patient Care Legislation

Many of the bills introduced during the last session dealt with improving the quality and/or efficiency of patient care. Among those which passed were the following:

H.B. 611, an ISMS supported proposal, eliminates the 2½ year retention requirement for X-ray films, and permits immediate reduction by any recognized means which does not destroy their usefullness for diagnostic purposes. H.B. 611 was signed on August 14th.

H.B. 871 allows establishment of a pilot program—lasting for 3 years—to determine the accuracy of lab work done by physicians' office labs. This bill requires each office to pass, within that 3 year period, a proficiency test designed to measure the precision of the work performed. H.B. 871 was also signed on August 14th.

H.B. 997 requires physicians employed by the Illinois Department of Mental Health to be trained in psychopharmacology.

H.B. 1291 was introduced in response to complaints from nurses that many of the duties they routinely perform under a doctor's supervision may technically be considered to be violations of the Nurse Practice Act. This bill establishes a Board of Opinion —composed of 3 practicing nurses, 3 practicing physicians, 1 nurse hospital administrator and 1 physician hospital administrator —whose function will be to periodically issue opinions as to specific procedures which may be within the scope of the practice of nursing. Governor Walker signed this bill on September 4th.

S.B. 27, already signed by Governor Walker, provides that no health or accident insurance policy written in Illinois may include a disclaimer of coverage for newborns and guarantees that newborn infants are insured up to policy limits for the first 60 days of life.

S.B. 525, also signed by the Governor, creates a new child abuse act, providing criminal penalties for those who do not report suspected cases of child abuse (while granting immunity from liability to those who do). This bill further provides that physicians treating children who may have been abused can assume legal custody of the child until such time as the Department of Children and Family Services can act.

S.B. 739, responding to an increasing demand for legal status for physicians assistants, provides for minimum standards of education, examination, and certification for licensure. It enables physicians assistants to perform such tasks within the supervising physician's specialty as he may assign, and does not prohibit physicians from continuing to employ technicians. Governor Walker signed S.B. 739 on September 12, 1975.

Public Aid

Senator Don Moore (R-Midlothian) introduced a series of bills designed to further regulate IDPA. Of this group, two passed, while action is pending on the others. **S.B. 946** requires IDPA to consult with the Legislative Advisory Committee on Public Aid prior to effecting any changes in fees or other payments to providers. **S.B. 947** requires the Department to establish rules regarding the dispensing of health care services and requires providers to keep records detailing the nature and extent of care provided. Governor Walker has vetoed S.B. 946, while signing S.B. 947.

In related developments, **S.B. 555,** the Department's appropriation bill, has been amendatorily reduced and signed by Governor Walker. Of significance is the approximately $50 million cut in the health services appropriation. Administration spokesmen indicate that this will result in a 5% reduction in reimbursement of health care providers, but that the actual cuts will be determined by the profiles of individual physicians. Experts indicate that, had the appropriation been left standing as passed, the health services appropriation would have been underfunded by $100 million, which makes the actual cut $150 million, rather than the $50 million listed by Walker. This could result in a 15%

(Continued on page 452)

Medichek-A Progress Report

By Joyce C. Lashof, M.D.,
Director, Illinois Department of Public Health

Medichek is the Illinois program of preventive health services for children and youth eligible for the Department of Public Aid's Medical Assistance Program. A joint effort of the Illinois Departments of Public Health and Public Aid, the program provides the screening portion of the Early Periodic Screening Diagnosis and Treatment (EPSDT) amendments to the Medical Assistance Program. Examples of medical services provided through the Medichek Program include periodic health appraisals, a comprehensive immunization schedule, and screening tests to detect specific conditions.

In the March, 1974 issue of the *Illinois Medical Journal,* we discussed the purpose and structure of the Medichek Program. In this issue, we report on the program's progress to date.

Question: how many children and youth received Medichek services since the program became statewide in March 1974?

As of March 31, 1975, a total of 106,705 children from birth through age twenty have received Medichek screening services. Of these children, 53,547 have had Medichek medical services, while 53,158 received dental services. Of those children receiving medical screening, 67 percent were in the 0-5 age range and 33 percent were 6 to 21 years old.

Have Medichek medical screenings discovered children who need further diagnosis and treatment?

Approximately 6 percent of the children receiving Medichek medical screenings are found to need referral for further diagnosis and treatment through the Medichek/Medicaid follow-up system. Most of these referrals are for diagnosis and treatment of abnormal conditions of the cardio-respiratory and neuro-muscular systems. Nutritional deficiencies are also commonly reported. Of those children given a hemoglobin screening, 9.1 percent are found to have levels below 10 grams; 15.7 percent of those given a hematocrit screening have readings below the 33 percent level. Despite a large increase in the volume of children receiving Medichek screenings, a follow-up system utilizing Illinois Department of Public Aid caseworkers has been developed and implemented. The purpose of the follow-up system is to assure that these children do receive needed diagnosis and care through the Medicaid Program.

The 6 percent referral level mentioned above does not include referrals for tuberculosis (1.2 percent of those screened had a positive reading); sickle cell trait (6 percent of those screened); blood lead (24 children) or venereal disease. These conditions are followed-up through other methods.

What is the status of physician participation in the Medichek Program?

The number of participating physicians and clinics has steadily increased during the past year. Much of this increase can be attributed to the efforts of the Department of Public Health's Medichek regional coordinators, who are responsible for developing provider participation. More than 1,500 physicians have submitted medical screening forms to the Medichek Program. Medical screening services are also provided by 25 public health and private clinics approved to participate in the program.

What program accomplishments would are to emphasized?

When the Medichek Program went statewide on March 1, 1974, we were screening less than 1,000 children per month, in five pilot projects. With expanded provider participation and increased efforts to reach the eligible population, the Medichek Program is now screening more than 15,500 children each month. Even with this increased volume, the program's ability to pay the providers of screening services has improved dramatically. More than 97 percent of the error-free Medichek bills are paid within 30 days after they are received.

What concerns face the Medichek Program at present?

It is often difficult to convince parents of the importance of regular, preventive health care and to motivate them to seek Medichek services for their children. Medichek staff are developing methods to reach those children in the eligible population who have not yet received Medichek services or who have failed to continue screening services on a periodic basis. From an administrative standpoint, a major concern involves duplicate billing for services. For example, the Medichek Program can pay for only one "five year"

scheduled medical screening for each child. Two different physicians might bill a "five year" scheduled visit for the same child, or one physician might give two medical screenings to the same child within the designated year. In either situation, the Medichek Program can reimburse only one visit. Computer-checking reveals these situations when they occur. Medichek staff are working with providers to reduce the number of duplicate billings. Staff are also attempting to alleviate two additional billing errors—case identification numbers which do not match, and the failure to indicate a child who is one of a multiple birth.

How can physicians obtain further information about the Medichek Program?

To answer any questions relative to the Medichek Program, call or write: Medichek Program, P.O. Box 1087, Springfield, Illinois 62705, (217) 782-2736.

You can also contact your nearest Medichek regional coordinator at one of the addresses listed below.

Region 1A
Jere E. Braden
I.D.P.H.
4302 North Main Street
Rockford, Illinois 61103
(815) 987-7511

Region 1B
Jere E. Braden
I.D.P.H.
5415 North University Avenue
Peoria, Illinois 61614
(309) 691-2200 Ext. 505

Region 2A
Tyrone White, Ph.D.
I.D.P.H.
421 North County Farm Road
Wheaton, Illinois 60187
(312) 653-0910

Region 2B
Mike Gelder
I.D.P.H.
160 North LaSalle, Suite 1100
Chicago, Illinois 60601
(312) 793-2777

Region 3A
John McCann
I.D.P.H.
Room 173, State Regional Office Building
4500 South Sixth Street Road
Springfield, Illinois 62706
(217) 786-6882

Region 3B
Marie Gronlund
I.D.P.H.
2125 South First Street
Champaign, Illinois 61820
(217) 333-6914 or 333-6996

Region 4
Lucille Helwig
I.D.P.H.
Cottonwood Road R.R. 4
Edwardsville, Illinois 62025
(618) 288-5756

Region 5
Robert Luebbers
I.D.P.H.
Route 3
2209 West Main Street
Marion, Illinois 62959
(618) 997-4371 Ext. 366 ◄

Legislative Report

(Continued from page 450)

reduction in fees. The Legislative Advisory Committee has already indicated that it will hold hearings on the subject and ISMS intends to have significant input into these hearings.

Chiropractic

Part of the avalanche of bills into this session of the General Assembly were a series of bills which sought to extend the power of the chiropractors. Of that number, only one bill—**S.B. 254**—passed. This amends the Blue Shield enabling laws in such a way to require the inclusion of chiropractic services in all Blue Shield policies. Presently, the law makes its inclusion an option, rather than a required service. Even more significant are provisions which enable chiropractors to vote for the election—and to stand for election themselves—of the physician members of the Blue Shield Board. This bill was signed on August 29th.

Blue Cross/Blue Shield

Also passed during the recent session were **S.B. 1387** and **S.B. 1447.** The recent signing of these bills pave the way for the merger of Illinois Blue Cross and Blue Shield.

Other Issues

The folowing bills also are of interest to physicians:

S.B. 417—requires IDMH to give relatives of patients 15 days notice prior to the transfers of patients from one state hospital to another, and was signed on September 15th.

S.B. 451—provides compensation for paramedics killed in the line of duty. S.B. 451 was signed on September 5, 1975.

S.B. 822 delays the effective date of the Alcoholism and Intoxication Treatment Act until July 1, 1976.

H.B. 271—creates the Rape Victims Emergency Treatment Act, requiring hospitals to offer emergency treatment of rape victims, and was signed on August 26th.

H.B. 278—prohibits insurance companies from excluding from coverage the treatment of rape victims. Governor Walker signed H.B. 278 on August 27th.

H.B. 1590—requires continuing education of optometrists.

H.B. 2398—creates the Sudden Infant Death Syndrome Study Commission. H.B. 2398 was signed on September 3rd. ◄

Doctor's News

SPECIAL SESSION OF THE ISMS HOUSE OF DELEGATES

The ISMS House of Delegates will meet Tuesday, November 11 and Wednesday, November 12 at the Forum Thirty Plaza in Springfield to determine a course of action in regard to professional liability solutions and medicines' relationships with state regulatory agencies. According to Chapter IV, Section 6, of the ISMS Constitution and By-laws, only matters pertinent to the purpose of the meeting may be considered or acted upon. Resolutions and other items pertaining to the subject will be accepted until the meeting opens; however, early submission of resolutions is urged. There will be a screening committee to determine the admissability of items submitted.

The schedule of the meeting is as follows:

Tuesday, November 11

9:00 a.m.	Registration
9:30 a.m.	House of Delegates opens
11:00 a.m.	District Caucuses
1:30 p.m.	Reference Committee hearings

Wednesday, November 12

9:00 a.m.	House of Delegates

Committees of the House of Delegates for the November Special Session

Committee on Credentials

Arthur Fischer (CMS) and
E. K. DuVivier (DS), *Co-Chairman*
Martin Meisenheimer (CMS)
William Perkins (DS)
John Pope (DS)

Committee on Rules and Order of Business

Lawrence Hirsch (CMS), *Chairman*
Frank Hussey (CMS)
John Hyde (CMS)
A. J. Kiessel (DS)
Paul Lorenz (DS)

Reference Committee A

(Professional Liability)

Joseph R. O'Donnell (DS), *Chairman*
C. Larkin Flanagan (CMS)
John Hubbard (DS)
Earl Klaren (DS)
Joseph B. Moles (CMS)

Reference Committee B

(State Regulatory Agencies)

Morris Friedell (CMS), *Chairman*
Samuel Andelman (CMS)
C. A. DeKovessey (DS)
Edward G. Ference (DS)

Reference Committee C

(to be used at discretion of speaker)

Vincent Freda (CMS), *Chairman*
John Harrod (CMS)
Vincent Sarley (CMS)

AMA MEMBERSHIP ROLLS INCREASE—As of mid-August the total dues paying membership in the American Medical Association had reached an all-time high of 173,221 paid physician members. This reflects an increase of about 6100 since August, 1974. The most dramatic membership gains in 1975 were among interns, residents and medical students, with more than a 50% increase.

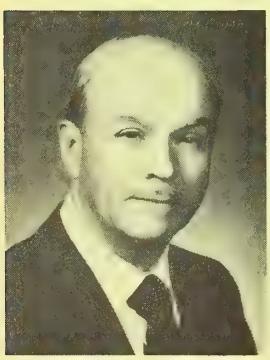
James H. Sammons, M.D., Executive Vice President of the AMA feels the membership rise clearly indicates that physicians support the concept of a single strong organization representing their views and assuming a leadership role in medical and health affairs.

UTILIZATION REVIEW REGULATIONS WITHDRAWN—The Department of HEW has agreed to withdraw the highly controversial utilization review regulations under Medicare and Medicaid, which a court order of May 27, 1975, prevented from being enforced. Accordingly, the lawsuit brought against HEW by the AMA was dismissed and a notice was published stating that changes would be made in the regulations. Any subsequent regulations will be published as proposed rules with opportunity for comment.

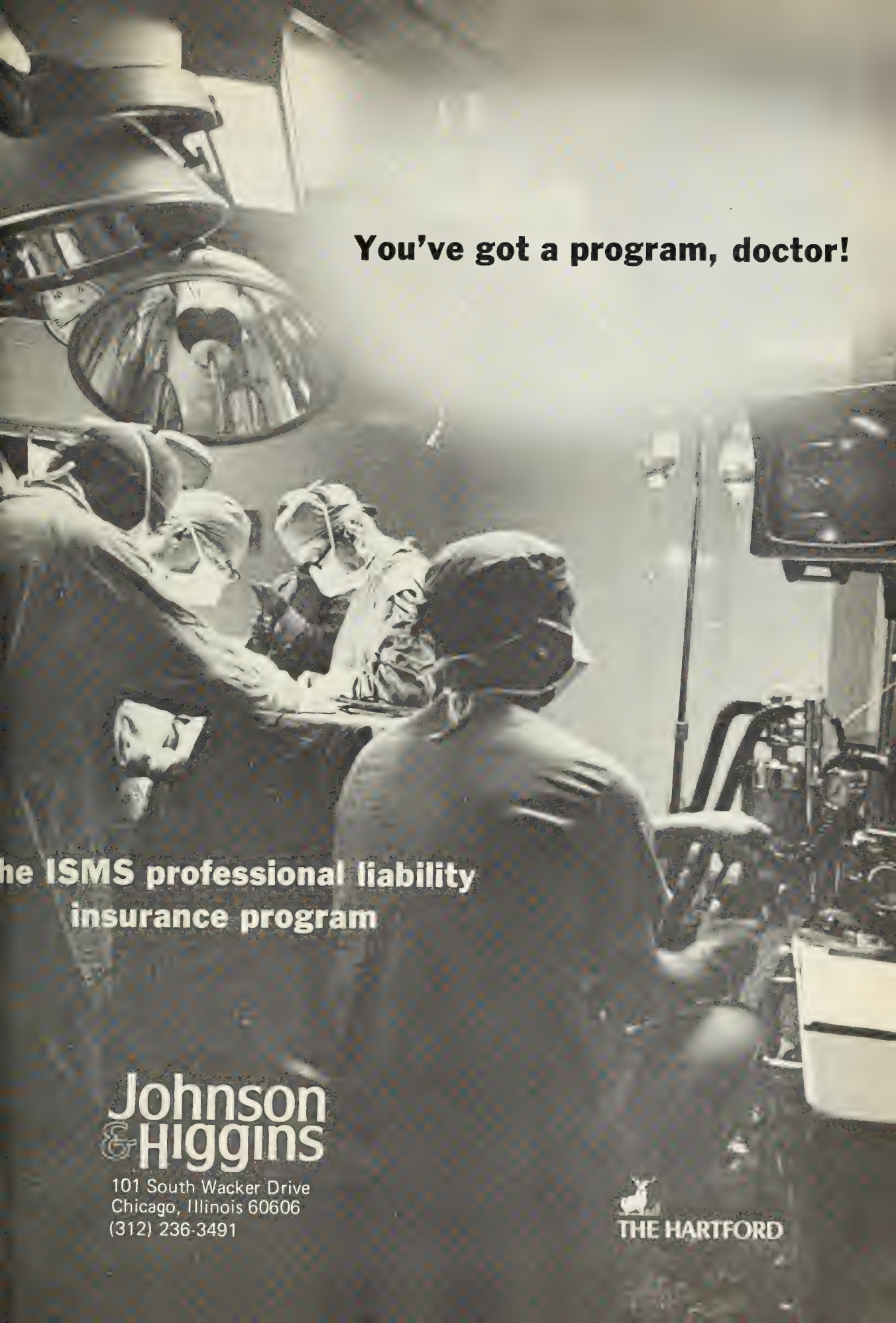
SIMA TO HOST ONE HUNDRED AND FIRST ANNUAL MEETING—The Southern Illinois Medical Association will hold its Annual Meeting on November 6, 1975 in Belleville. The morning session will feature two clinical lectures by John G. Masterson, M.D., Professor, Obstetrics and Gynecology, Stritch School of Medicine, Loyola University. This will be followed by a Business Meeting and Luncheon with guest speaker Jerry L. Beguelin, M.D., Irvington, discussing "Rural Health in Southern Illinois."

The afternoon session will offer a panel discussion of "Allergies and Common Skin Disorders." H. L. Lange, M.D., Clinical Professor of Pediatrics, St. Louis University School of Medicine, will be the moderator with panelists Clement J. Sullivan, M.D., Associate Professor of Clinical Medicine, St. Louis University School of Medicine and Elliot A. Wallach, M.D., Assistant Professor of Clinical Dermatology, St. Louis University School of Medicine. For further information contact W. H. Walton, M.D., 109 South High Street, Belleville 62220.

ILLINOIS PHYSICIAN APPOINTED TO STATE POST—**Dr. Willard C. Scrivner,** past-president of the Illinois State Medical Society, has been appointed to the state's Judicial Inquiry Board. Dr. Scrivner, of Belleville, Ill., is one of four non-lawyer members of the board. Dr. Scrivner currently serves on HEW's National PSRO Council. An obstetrician and gynecologist, he was a member of the ISMS Board of Trustees for nine years and Board chairman for two years.



Dr. Scrivner also is past president of the Illinois Obstetrical and Gynecological Society, the St. Clair County Medical Society and the Mental Health Association of St. Clair County. He is a diplomate of the American Board of Obstetrics and Gynecology and a fellow of the American College of Surgeons.


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President's Page

Another Look At 'Consumerism'

The time has come to raise a few questions about the sacrosanct "consumer movement!"

It is difficult to discuss consumer involvement in medical care without evoking an emotional response. While this concept—like many other proposed innovations—possesses a certain degree of good, it also contains the inherent danger of overuse and continued blind acceptance. It is imperative that the concept be subjected to re-evaluation to establish its true worth.

As a profession—and as individuals—we need increased communication with patients to learn more about their concerns and expectations. The lack of such communication currently is a distinct deficit within our profession. While this deficit can be corrected, some consumerism concepts need reevaluation. For example:

- Does possession of a "state of health" automatically make an individual more knowledgeable about maintaining or changing that "state"? Not any more than the act of flying makes you an expert at piloting the aircraft!

- It appears to me to be ludicrous to fill a majority of the positions on a regulatory board with members whose *only* qualification is a *lack* of medical training or experience. Does it not follow that as they become *more* knowledgeable through service on a board, they become *less* qualified to represent "consumers"? And contrary to declarations by idealists promoting the "consumerism" concept, many board positions have been filled by people who represent a vested interest. Obviously, these appointees work for that interest, often at the expense of the true "consumers."

- How many consumer-dominated boards have I seen fighting for allocation of funds to an area or project simply because it is self-serving? Far too many, I'm afraid!

- Is it proper for an automobile dealer—whose business is moving merchandise—to apply the same hard-sell philosophy to the sale of hospital beds whether or not they are needed? Is it proper for a contractor—involved in a business that appears to accept "kickbacks"—to apply the same philosophy to medical care delivery? *We call that fee splitting and have condemned it for years!*

Obviously, many of the moral and philosophical facts that govern our professional lives are not fully recognized by those not involved in daily medical care activities. I maintain that the "consumerism" concept may have been initiated partially to answer a need for us to listen to—and learn from—our patients. However, I believe it is time that we discount the egotistical attitude of "consumer advocates" who maintain that a consumer majority on boards is an answer which supplies all good and no bad.

J. M. Ingalls, M.D.

J. M. Ingalls, M.D.

Following is a list of the remaining appearances by Dr. J. M. Ingalls as part of the Illinois State Medical Society's annual "President's Tour":

Date	County Society	Location
Oct. 21	Kankakee	Kankakee
Oct. 28	DeKalb	DeKalb
Nov. 4	Madison	Edwardsville
Nov. 13	LaSalle	LaSalle
Nov. 18	Lake	Waukegan
Nov. 20	Jefferson-Hamilton	Mt. Vernon
Nov. 25	Macon	Decatur
Jan. 6	Winnebago	Rockford
Jan. 14	Will-Grundy	Joliet
Jan. 20	Peoria	Peoria
Feb. 10	McLean	Bloomington
Mar. 9	Sangamon	Springfield

Otitis Media and Bottle Feeding

Small children who are bottle fed while lying supine were shown recently to be more prone to develop otitis media than other children. The eustachian tubes, which are normally closed, open upon tensing of the soft palate, as in swallowing. Beauregard[1] observed that contrast material spurted jet-like into the cartilaginous portion of the eustachian tube. With increased intranasal pressure, the contrast material occasionally entered the middle ear cavity. Even in healthy infants, the contrast material remained in the middle ear cavity up to 10 minutes before clearing. Breast-fed infants, almost always, are fed while supported upright. In addition, breast feeding does not require as strong a negative pressure as does bottle sucking. It is apparent that breast feeding, per se, helps to prevent otitis media in young children and that when bottle feeding is employed, the supine position and bottle propping should be discouraged. (Ralph D. Feigin and Margan J. Chang: "Treating Otitis Media." *Drug Therapy* (Sept.) 1974, pgs. 116-125).

Reference

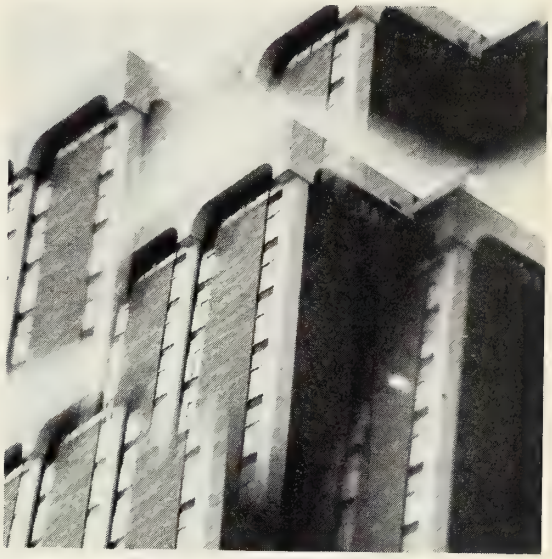
1. W. G. Beauregard: Positional otitis media. *J. Pediat.* 79:294-296, 1971.

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A Solution to Emergency Room Service in a Community Hospital

By John W. Ovitz, Jr., M.D./Sycamore

The care of sick people in or out of the hospital is the physicians "stock in trade." Hospitals per se are not licensed to nor capable of practicing medicine. They have been forced by circumstances, however, to assume more and more responsibility for out-patient care, often without the full cooperation of the practicing physician. It is with the belief that only with physician counsel and cooperation can a community hospital operate an Out Patient Service satisfactorily, that the primary physicians and the governing board of the Sycamore Municipal Hospital (S.M.H.) have worked out a modus operandi for all Out Patient Services and for Emergency Room Service in particular.

Formation of a Corporation

The primary admitting physicians of the Sycamore Municipal Hospital organized a not-for-profit corporation in 1968 to "improve and enhance the opportunities and attractiveness for the practice of medicine in Sycamore" by "providing counsel and funds for the physical expansion of the medical care facilities in the Sycamore area." This organization is known as the Sycamore Medical Fund, Inc. (S.M.F.) and was granted exemption from Federal income tax under section (501) (c) (3) of the Internal Revenue Code of 1954 beginning July 26, 1973. It was further determined that the S.M.F. is not a private foundation. The time and effort spent in order to receive this IRS recognition is a separate story. The Sycamore Medical Fund Inc. (S.M.F.) and the Sycamore Municipal Hospital are the two not-for-profit organizations involved in the following operation.

An agreement was worked out, and finalized in the form of a contract, which sets up a committee for out patient services (O.P.S.) This committee consists of 3 members of the Hospital Board of Directors (B.O.D.), three physician members appointed by the S.M.F. and the hospital administrator. This committee is responsible to the hospital board of directors for the general policies in respect to all out patient services, and for all detailed policy of the Emergency Room Services, provided there is no paid emergency room medical staff. The degree of committee involvement in the out patient services of laboratory, X-ray, physical therapy, surgery, and inhalation therapy would depend upon the presence of the appropriate physician specialist and the size of the hospital. The contract specifies that Sycamore Medical Fund, Inc. will receive a percentile of all emergency room charges as a donation in return for the counsel of its members.



JOHN W. OVITZ, JR., M.D., has had a private practice in General Medicine since his discharge from the U.S. Army Medical Corps in 1946. Presently he is Secretary of the Sycamore Medical Fund, Inc. He has also been a member of the Board of Education of School District 427 for eight years and is a Past President of the Sycamore Chamber of Commerce.

Responsibility for Service

The question of who is to render physician medical service in the emergency room was solved by a requirement of the Hospital Medical Staff that all primary physicians be responsible for emergency call in a rotating fashion. Each primary physician was given the option either to enter into a contract with the Board of Directors by which he must submit all of his emergency room fees to the hospital for collection at a guaranteed percentage or to submit none of his fees. If the physician chose to enter this contract he had to submit all fees generated in the emergency room at the usual and customary charge. The Out Patient Services committee would serve as a review committee for any complaints on fees or services.

At present, the physician receives 70% of his usual and customary fee, the Sycamore Medical Fund receives 10% for its charitable purposes, and the hospital keeps 20% to cover collection charges and uncollectables. The S.M.F. also receives a donation of 10% of all other emergency room charges.

The physicians of the Sycamore Medical Fund believe that the strongest motivation for a physician to accept the onerous task of rendering emergency room services on an on-call basis is through a mechanism whereby the hospital acts as his collection agency and assures him of a percentage of his fee. Those physicians who contract to the hospital as described above also submit any fees for services they render their own patients in the Emergency Room when not on call. An advantage to the patient is that all charges for his emergency service are submitted in one consolidated bill.

Emergency Room Record

The problem of a physician's claim to certain patients who appear in the emergency room when he is not available was solved by designing a new emergency room report sheet in quadruplicate (Fig. 1). This report sheet has all statistical information on the top quarter of the page along with space for a signature to authorize treatment. Next a space is provided for "Physician Requested." Then the middle half of the sheet is devoted to medical information. The lower fourth of the sheet provides space for instructions to the patient with his signature of acknowledgement. This latter signature also authorizes the release of information for insurance claims and the payment of fees directly to the hospital.

SYCAMORE MUNICIPAL HOSPITAL
EMERGENCY ROOM RECORD

Name_____ SEX M F DATE OF BIRTH / / CIVIL STATUS M S W D SEP

Address_____ Home Phone_____

Relative;
parent, guardian, friend_____

Insurance;
name and number_____ Employer:_____

AUTHORIZATION FOR EMERGENCY TREATMENT Date_____ Time_____

The undersigned has been informed of the emergency treatment considered necessary for the patient whose name appears above and that the treatment and procedures will be performed by physicians, members of the house staff and employees of the hospital. Authorization is hereby granted for such treatment and procedures.
The undersigned understands that a personal physician is to be selected by or on behalf of the patient within 24 hours if hospitalization or further treatment is required, or immediately if complications arise.
The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the results that may be obtained.

Witness_____ Signed_____
PATIENT OR AUTHORIZED PERSON

History of Injury or Illness: Physician Requested_____

Findings on Exam.:

Diagnosis:

Treatment: Tetanus toxoid_____cc. Tetanus Antitoxin Test_____Units

Signed_____M.D.

Instruction to patient: (Or hospitalized under service of _____ M.D.)

I have received and understand the above instructions; and I hereby authorize release of such information as may be necessary for completion of my hospital and physician insurance claims and authorize payment be made directly to the hospital and physician.

Witness_____ Signed_____ Date_____

RECORD ROOM COPY

When a patient is admitted to the Emergency Room, he is questioned as to the physician of his choice. This is recorded and usually determines who will give follow up care. The "on-call" physician renders the emergency service if the physician of choice is not available. He then refers the patient back to the physician of choice or hospitalizes the patient on that physician's service. When further care is necessary, this obviates controversy about who is to assume care of the patient and leads to more cooperative and tranquil staff relationships.

If the Emergency Room form is completed as it should be, the hospital record department and physician have all the information that is necessary for subsequent insurance reports or court appearances. It is a constant battle to get physicians to give legible comprehensive reports of treatment rendered in emergency rooms, but this form simplifies the chore and encourages completeness.

Conclusion

To date all physicians have chosen to contract with the hospital as their collection agency. This system obviates the physicians from setting up accounts for one time treatments in their business offices and promises regular reimbursement within 60 days of the month the service was rendered. So far there have been no complaints registered if either of the charitable organizations have made a profit on their services.

This may be an unusual way to generate funds for eleemosynary purposes, but the Sycamore Medical Fund has accumulated enough assets to make substantial contributions for equipping a new emergency room and the modest expansion of the physical plant. It has also instigated an annual Licensed Practical Nurse scholarship program and helps to underwrite the Medical Education and Community Orientation program for students at Sycamore Hospital. The Fund is also providing funds for the continuing in-service training of both nursing and medical staff. The Board of Directors of the Sycamore Medical Fund, all of whom are primary physicians, believe that its' potential for the community is great.

In summary this small group of physicians has organized a charitable corporation for the promotion of better medical care in its community. The physicians have shared their professional know-how with an understanding lay hospital board in an effort to provide better emergency room care with unified, prompt billing. At the same time, the Fund has generated funds for improved community relations. ◄

MANUSCRIPT INFORMATION

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed.

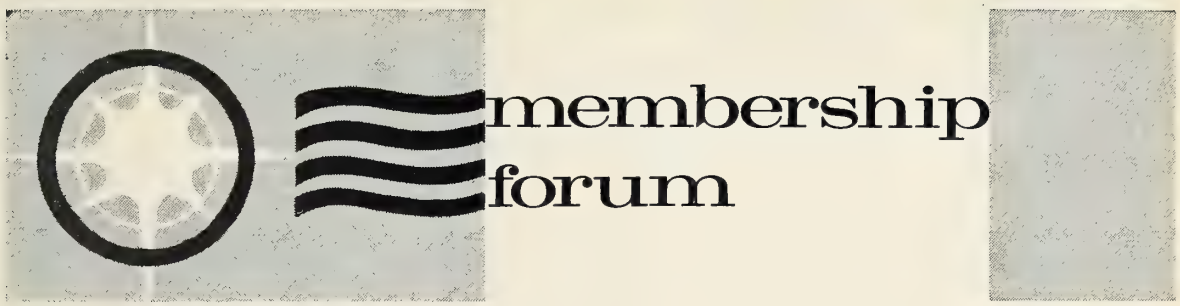
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References should be numbered in order of appearance in the text and conform to the following style in the order given: name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Make drawings and charts in black ink. If photographs are submitted, send black and white glossies. Number illustrations consecutively and indicate their place in the text. Number, indicate the top and place the author's name on the back of each illustration.

Address manuscripts to:

T. R. Van Dellen, M.D., Editor
Illinois Medical Journal
55 E. Monroe St., Suite 3510
Chicago, Ill. 60603



Dear Editor:

In Dr. Edwin E. Goldberg's article "Sideropenic Dysphagia" (*Illinois Medical Journal,* Volume 148, Number 2, page 136) he states that postcricoid carcinoma "is the only part of the gastrointestinal tract in which carcinoma is more common in females." According to Ca-A Cancer Journal for Clinicians, Volume 25, Number 1, January-February of 1975 (published by the American Cancer Society), it is estimated that there will be 31,000 new cases of carcinoma of the colon in men as compared to 38,000 new cases occurring in women. Additionally, they estimate 17,900 deaths from cancer of the colon occurring in men as compared with 20,700 in women.

I thought that this insufficiently appreciated set of data should be made available to your readership.

Respectfully submitted
Richard Gardiner, M.D.

Dear Dr. Van Dellen,

I wish to thank you for your editorial—" 'Plucked' by Legal Eagles." You speak for many of your peers, who are busily engaged in dispensing care and working the vineyards in other ways. Your article identifies what they think and say about the present state of affairs in America—exasperating!

Best Wishes,
Dan Chamberlain, Ph.B., M.D.

Musical Hallucinations

Auditory hallucinations have been associated with a wide variety of organic and functional disorders. Complex musical hallucinations are less common but have been described as a symptom of both cortical and subcortical neurologic disease. We report the case of a 64-year-old woman, profoundly deaf since her early teens, who developed almost constant musical hallucinations. Before her deafness, the cause of which had never been found, she had demonstrated musical talent. Her hallucinations took the form of music that she had learned or heard prior to her deafness, such as religious hymns, popular tunes, and portions from semi-classical compositions. She never heard words. (Francis M. Forster and Stephen A. Barron: "Musical Hallucinosis in a Deaf Person." *Wisconsin Med. Jl.* (Feb.) 1974, pg. S21).

The Rubella Law Revisited: A Perfect Model of Bad Medical Legislation

By Lucia Fischer-Pap, M.D./Rockford

A middle age couple walked into my Rockford office sometime ago, shortly after the Rubella Law had been passed in Illinois. The man was from another state and had come to Rockford to get married. His bride was a handsome woman in her fifties, but at that moment she looked very distraught. Apparently she had just had a pre-marital blood test for venereal disease plus the Rubella-antibody test, in compliance with the brand new Illinois Law. Now she needed an affidavit from her physician to show the county clerk, stating that she had been properly "counseled" regarding the result of the test.

The problem was, however, that her physician didn't live in Rockford, as she was from the Chicago area, but for personal reasons had chosen to get married in Rockford. Without this affidavit, the blood test that had been done and the proper certificate she was holding were not enough to allow a legal marriage ceremony to take place.

I had never seen this couple before; they happened to have wandered into our office on their way to an attorney's office in our building, whose advice they were planning to get after seeing us. I am not in general practice, was barely aware of the new Rubella Law and had an office full of patients. I had to make a real effort to listen patiently to their story, and try to help them.

I pulled out the circular I had received about the new Illinois law and read it again. The law required that the woman be counseled by a physician about the test and it's result, and that proof of this counseling, (a blue form I couldn't find) be attached to another form, issued by the laboratory where the test had been done. However, the result of the test was not available yet. The wedding reception was in a few hours, the woman was beyond childbearing age and had had the German measles as a child. She had also had a hysterectomy at age 45.

Neither one of us could understand what the purpose of this "counseling" could possibly be, as her chances of ever contracting German Measles while being pregnant were less than the chance that the resurrection of William the Conqueror might take place in my waiting room at that moment. These two people had become the innocent victims of a bad law—designed in appearance to protect unborn children from the dangers of congenital German Measles.

At that moment, however, its value in that respect was questionable to me. It's nuisance value was, on the other hand, crystal clear to all three of us, standing there in the crowded hallway of my office.

She finally remembered the name of a general practitioner who had taken care of her Rockford relatives for years. His office was only a few minutes from mine and a quick phone call solved the problem. The good doctor had the required blue forms recently issued by the State (which I had probably filed away thinking I would never need them). He also had records on file on the woman's family and was fortunately willing to complete and sign the affidavit.

A Legislative Stillborn with Good Intentions

I would have loved to get my hands on the available legislative voting records on this law. For, even if their intentions were good—the legislators who voted for the passage of this law obviously lacked the essential medical information that would have made it's wording effective, or at least rational.

Rubella is the mildest of the childhood diseases, as we all know. However, to eliminate the ravaging effects of congenital Rubella on the offspring of mothers contaminated with this virus; a massive nation-wide program of vaccination was started in the public schols some four years ago. This effort was highly successful, as there were no further epidemics of Rubella, once the school immunization program was in effect.

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The program, by the way, was the first of its kind in medical history, as it was designed not to protect the recipients themselves, but rather to protect the unborn next generation. Why did the State of Illinois then—unlike the rest of the Nation—decide to pass an additional Rubella-antibody testing law? Here is an account of the birth and death of this irrational law, why it was passed and why it was doomed to oblivion after a precarious two-month survival:

On September 20, 1972, the Department of Public Health of the state of Illinois notified physicians of the approved House Bill #1324, which read in part:

> *"No marriage license shall be issued unless there is filed with the county clerk an affidavit signed by a duly licensed physician stating that he has administered to the woman a test of immunity to Rubella, known as German measles. A physician's affidavit shall not be required when a woman making application for a marriage license files with the county clerk her affidavit certifying that immunizations are contrary to her religious convictions and setting forth information relating either to her membership in a religious denomination which includes such convictions in its teachings or to other facts upon which such convictions are based."*

This routine premarital blood test for the presence of antibodies against German measles in all women desiring to marry was immediately made available by a number of laboratories. In our county of Winnebago, the Director of Public Health announced that the test could be performed on the same blood specimen used for the routine premarital venereal disease test, and the additional cost would be only $4.00.

After Passage of the Law

Little had been written about the law before it was passed, therefore it was received with:

1. Complete lack of understanding from the public.
2. Utter confusion among county clerks, officials and the press.
3. Amazement and disbelief in medical circles.

The flaws of this law were unbelievably numerous. The possible future benefits hardly tangible at all. Let me remind you that; as most physicians noticed immediately:

1. The law applied to all women seeking marriage regardless of age. It included women of childbearing age, as well as older women in their fifties or sixties, and those who had had a hysterectomy or sterilization, and would therefore, never bear children.
2. It also included women who were already pregnant at the time of their marriage.

Consequences of the Law

The law made it mandatory that all women be tested for Rubella before marriage. But:

1. It *did not* explain that the test was harmless and did not give any protection against the disease.
2. Neither did it explain that the live-virus vaccination that should follow—if the test revealed that the woman had no immunity —*was* dangerous to her baby if she was pregnant or planning to become pregnant within 3 months of her wedding date.
3. It *did not* exclude or excuse women who had had German measles in childhood, and those who could not bear children anymore, by virtue of age or surgery. It did exclude however, those who claimed "a religious reason" to be excused.

In the few weeks that followed, while bewildered city and county authorities were trying to enforce it, it became apparent that this law was doomed to failure.

Among items of confusion that followed:

1. People thought that the test was a vaccine and that it was either dangerous or immunizing. Of course, it was neither.
2. People also thought that a positive test meant that the woman *had* rubella, rather than protective antibodies against it.
3. The *"counseling"* the doctor had to do before attaching the blue form, was often interpreted to be on pregnancy and birth control in general, rather than about the rubella vaccine in particular.

Why did this Law Pass?

Only the pharmaceutical labs which sold the kits for the test benefited, so rumor had it. These pharmaceutical firms, it was said, had pushed this piece of legislation—hoping to sell the materials for the test to all the laboratories in the State. Hence the *good* reason for this law was officially to protect mother and baby from Rubella. The wording of the law however made this nearly impossible. So it became apparent that one *real* reason behind such ill-researched law might have been one of economic gain.

After a few weeks the obvious medical conclusions were the following:

1. Most women who took the test either were already immune or didn't need to be im-

munized as they were not going to get pregnant.

2. Those who *did* need to be immunized—the young women of childbearing age—either never found out about the result of the test or could not be given the vaccine anyway, as it was too dangerous to do this without the absolute certainty that pregnancy would not occur within a few months. And who could get *that* kind of assurance from any young girl? Doctors were reluctant to expose the woman to the added risk.

Besides, there were other medical reasons for being reluctant to give this vaccine to adults—it often causes fever and joint pains in people over the age of 13. The general reaction in medical circles was that the majority of school-age children were already being vaccinated early in life to avoid any future epidemics. Vaccinating young women is risky and generally not recommended. Also, the abortion laws had already been liberalized enough throughout the nation to permit abortion in the case of a woman who contracts German measles during pregnancy. What then, was the purpose of this law? Merely determining whether the woman was or was not immune to German measles was completely irrelevant and a law that forced people to undergo such test as a condition to legal marriage, was useless.

Conclusion

A strong movement against this law was immediately started by Representative W. Timothy Simms, the county medical societies and the press. By March of 1973 it went back to the Illinois House of Representatives, where it was repealed by an overwhelming majority of 120-1.

This story has a happy ending: few people were affected and little damage was done by this short-lived, ill-conceived piece of medical legislation. Democracy and common sense triumphed within a few months. Yet, the Illinois Rubella-testing law remains an ideal model for future legislators to study: *It is a perfect example of how incompatible hasty politics and good medicine really are.*

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Staged Repair of Gastroschisis With an Enteric Fistula as a Complication

By Leonardo M. Chato, Jr., M.D., Arne E. Schairer, M.D., F.A.C.S., and Robert L. Schmitz, M.D., F.A.C.S./Chicago

Gastroschisis and antenatal rupture of omphalocele are rare congenital anomalies. For many years the mortality rate was very high with the average rate of 48%.[1-4] The high fatality rate was significantly reduced when staged repair was introduced. Ladd and Gross,[5] set forth a general principle of a two-staged repair of the abdominal wall. The mortality rate, however, even with staged repair was still significantly high, prompting Schuster,[2] Hutchin,[6] and Allen[7] to devise various surgical techniques using materials like teflon mesh and silon in an effort to reduce the mortality rate. This prosthetic material is used to form a sac for the extruded viscera, while the peritoneal cavity is allowed to grow in size for subsequent staged repair. The survival rate using staged procedure with silon increased from 38 to 68% as reported by Girvan, et al.[8]

However, this current popular technique of using a temporary sac is not entirely free of complication. Raffensberger and Jona,[9] reported a method of treating gastroschisis by forceful manual stretching of the abdominal wall and skin closure without undermining of flaps. They reported a mortality rate of 16%.

This is a case report of a successful staged repair using prosthetic material in the treatment of gastroschisis with an enteric fistula as a complication.

Case Report

A six-pound, full term, 40 weeks gestation baby girl was born to a 23-year-old primigravida with Apgar score of 4-5 at 1 minute and Apgar score of 7 at 5 minutes. The baby required resuscitation after birth with good response. The physical findings were that of a full term female with pallor but no cyanosis or any respiratory distress. Heart sounds were normal and no heart murmurs were noted. The lungs were fully expanded. The abdomen showed eviscerated small and large intestines, stomach, uterus, fallopian tubes, ovaries, full urinary bladder and behind the stomach and duodenum, a portion of the liver seen protruding out of the defect in the anterior abdominal wall. There was no evidence of any peritoneum or amniotic sac. The defect in the anterior abdominal wall measured approximately 4 to 5 cm., located adjacent to the right of the umbilicus.

Warm, moist saline lap pads and bulky dressings were applied to the extruded viscera. The baby was prepared for immediate surgery and 1½ hours after birth was intubated and under general anesthesia; exploration was carried out. The extruded intestines were matted and edematous with thick yellowish fibrinous exudates producing adhesions between the loops of small intestines. The entire small intestine and colon were rotated 180 degrees lying outside the abdomen. Although there was marked edema, the intestine was intact including normal rectum. The intestines were moistened from time to time with warm saline.

Procedure

The fascia of the anterior abdominal wall was identified at the margin of the circular defect. The prosthesis of mesh was sutured to the fascia and fashioned into a cylindrical sac to contain the eviscerated loops of bowel (Fig. 1). The cylindrical prosthesis was covered with a rubber glove to prevent the bowel from becoming dehydrated. One end of a small catheter was left in the glove through which to provide moisture for the bowel.

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Figure 1. Marlex mesh was sutured to the fascia and fashioned into a cylindrical sac to contain the eviscerated loops of bowel.

The glove and cylindrical prosthesis was suspended above the baby's abdomen by an overhead traction arrangement in the Isolette.

The material used for the sac was a heavy gauge 6 Mil Monofilament polypropylene with a trade name Usher's Marlex*.

Post-Operative Course

Post-operatively, under sterile conditions, attempts were made to reduce the loops of bowels in the sac by squeezing from the top and tying the sac with 0-silk at intervals of 2-3 days. Local and systemic antibiotics were used to help control infection and peritonitis. Neomycin 0.1% with saline 100-300 cc per 24 hours dripped into the rubber catheter. Penicillin, Kanamycin and Gentamycin were used to control local and systemic infection. Initially gamma globulin 1 cc was given.

On the fourth post-operative day, an external jugular cutdown was done and a polyethyline catheter was inserted into the superior vena cava and intravenous hyperalimentation started. The baby was given intravenous hyperalimentation for four weeks without complications. On the eighth post-operative day, bile staining on the left side of the mesh was noted as well as an increase of rectal temperature to 101-102 degrees F (Fig. 2). A small bowel fistula was considered and the patient was brought to surgery. The mesh was removed carefully. Meconium staining was noted scattered in different areas inside the mesh. Cultures were taken and the bowel was carefully washed with warm saline solution. The loops of bowel were adherent in a pear-shaped manner with all details obliterated by adhesions and granulation tissue making identification and separation of the bowel loops technically impossible. The merconium leak was identified.

In an attempt to reduce some of the pear-shaped loops of adherent and matted bowel, the abdomen was opened through an incision that was made from the upper edge of the defect in the midline up to the xiphoid process. The extruded viscera were almost completely reduced. The mucosal leak was exteriorized by making a separate incision in the left upper abdominal wall at the site the defect was located within the abdomen. The portion of the bowel with the fistula was brought out to the skin through this incision forming an ileostomy. A new mesh was sutured to the peritoneum and fascia. Culture from the fistula grew Herella Achromobacter and Streptococcus. These were treated with Neomycin and Gentamycin.

Final Operation

One week after the second operation, barium swallow, barium enema, and barium study through the exteriorized fistula showed patent gastrointestinal tract from stomach to anus. The thickness of the edema of the exteriorized bowel subsided. Five days later the third and last stage of abdominal wall repair and the repair of the ileal fistula were done successfully with two-layer anastomosis. The subcutaneous tissue and skin were not closed and allowed to heal by granula-



Figure 2. Bile staining on the left side of the Marlex mesh was noted on the 8th post-operative day suggesting an enteric fistula.

*Catalog #1266, Davol Inc., Providence, R.I.

tion. The baby was discharged on the 29th hospital day in good condition. At follow-up four months later, the baby was found to be healthy and well with normal growth and development.

Discussion

It is apparent from the review of medical literature that survival rates have significantly increased with the introduction and refinement of the staged procedures and the ancillary aids of different prosthetic materials forming a temporary sac as an initial treatment. The end result of this procedure is the gradual reduction of eviscerated visceral organs into a slowly enlarging abdominal cavity, thus preventing fatal complication of cardiorespiratory distress. Gastric decompression immediately at birth and prompt surgical intervention influence the survival of these patients.

Tube gastrostomy was performed in those series with higher survival rate.[1,3,4] Gamma globulin, local and systemic antibiotics instituted in this particular patient, as in other series, diminished the risk of infection.[1,4] Several local antibiotics had been used and we feel Neomycin 0.1% used in this patient is as effective as others in controlling the infection. Allen,[7] in his later cases, successfully used 0.5% silver nitrate solution.

One interesting aspect in this patient's postoperative course was the development of a small intestinal fistula eight days after the first operation. The cause of this fistula probably was the pressure produced by the manual reduction and pressure from the prosthetic sac. A similar complication was found in one of the patients of Schuster's[2] series who died. He attributed the development of superficial intestinal fistulas to the firm prosthetic material that was used. Allen[7] reported a similar small fecal fistula which he attributed to the trauma probably induced by manual reduction of the sac. Their patient, like this case, despite the complication, survived. But even without the use of prosthetic material as a sac, Rickham[10] reported one of the two survivors developed fecal fistulae after primary closure of the abdominal wall. The fistulae healed spontaneously.

One very important factor, we feel, that influenced the survival of this patient, was the institution of intravenous hyperalimentation.

Summary

A case of successful surgical treatment of gastroschisis with an enteric fistula as a complication is reported. Immediate operation was performed and a temporary sac using Marlex mesh was created. Gradual manual reduction of the sac into a slowly growing abdominal cavity prevented the serious complications of cardiorespiratory distress and intestinal obstruction. The enteric fistula was probably caused by the pressure produced by the manual reduction and pressure from the prosthetic sac. The treatment for the enteric fistula was exteriorization and secondary closure. ◄

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Cystic Fibrosis: Involvement of the Ear, Nose, and Paranasal Sinuses

By Daniel G. Cunningham, M.D., William M. Gatti, M.D.,
Ann Marie Eitenmiller, M.S., and Paul N. Van Gorder, B.S./Maywood

A report on a study of the otolaryngological aspects of cystic fibrosis. Results demonstrated involvement of the paranasal sinuses in all cases with a high incidence of nasal polyps and failed to demonstrate significant hearing loss.

Cystic fibrosis is a condition characterized by multiple system manifestations and widely variable symptoms which are expressed only in the homozygote patient. Heterozygotes, including obligate heterozygous parents, are always entirely free of all clinical manifestations of the disease.[1] Until recent years, interest in cystic fibrosis centered largely on pancreatic and pulmonary manifestations of the disease since the majority of patients died of pneumonia or malnutrition in the first two years of life. In recent years, the clinical spectrum of cystic fibrosis has changed because of an increased awareness of the disease resulting in earlier diagnosis, together with improved methods of therapy.[2] Today, most individuals with cystic fibrosis survive into adolescent and adult life and constitute a large group of patients since cystic fibrosis is a condition of high incidence. These patients are of particular interest to the otolaryngologist, and frequently present to him with significant manifestations of the disease related to the ears, nose, and paranasal sinuses.

The purpose of this article is to report on a study of the ears, nose, paranasal sinuses and hearing of patients with cystic fibrosis at various age groups and as the findings relate to such factors as age, severity of pulmonary disease, and general health status as measured by Shwachman Scores.[3]

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Materials and Methods

All twenty-six patients admitted to the study were being followed at the Loyola Cystic Fibrosis Clinic. In each case, the diagnosis was confirmed by sweat electrolyte studies.[4] No patient was excluded from the study on the basis of the severity of the disease. All patients had chest X-rays and X-rays of the paranasal sinuses. Chest X-rays were graded as mild, moderate, or severe reflecting the severity of pulmonary disease. Shwachman scoring was used to evaluate the patients' overall status, the grading being excellent, good, mild, moderate, and severe.[3]

Each patient had a complete clinical evaluation of the ears, nose, and throat by an otolaryngologist. X-rays of the paranasal sinuses were evaluated by the otolaryngologist and compared independently with the formal radiological report with which there was no significant disagreement in any case. Cultures were done repeatedly on the nose and throat in all instances and of nasal polyps and ear discharges, if such existed. Audiometric studies were performed on all patients except for the four youngest patients in the series, because play audiometry was judged unreliable. Air conduction pure tone testing was done on all patients. Bone conduction and speech reception thresholds were performed on those patients showing thresholds greater than 20 dB. I.S.O.: at 2 frequencies between 250 and 4,000 HZ.

Hearing

Twenty-two patients had audiometric studies performed. None had severe hearing loss and none had nerve conduction loss. This is of interest since many patients had received ototoxic antibiotics (mainly Neomycin and Colistin) by inhalation for long periods of time and few had multiple courses of intramuscular Gentamicin. One patient has been taking Gentamicin daily by intramuscular injection for over a year.

Eight of the twenty-two patients exhibited mild degrees of conductive hearing loss which was bilateral in only two instances. One of these patients was a six year old boy who had bilateral serous otitis requiring tube insertion which was subsequently complicated by streptococcal and stapholococcal otitis media. Four of the seven cases with nasal polyposis also had a mild conductive hearing loss. In no case did the hearing loss exceed 25 decibels in any range.

Nasal Polyps

In the study group of twenty-six patients, nasal polyps were detected in seven or 27% of the study group. No polyps were observed in patients under five years of age. The incidence of polyps in older children increased to 36% (see Table I).

Table I
Nasal Polyps

Age	Total Number of Patients	Polyps	Requiring Polypectomy
Under 5 years	7	0	0
5-12 years	10	1	0
12-20 years	9	6	2

In two teenagers in the group, polyposis was the most distressing manifestation of the disease at the time of the study, and polypectomy was performed in both patients. This is in keeping with the observation that, in this group of cystic fibrosis patients, the incidence and degree of obstruction of polyps seemed to be inversely proportionate to the severity of the disease in general as measured by Shwachman scores (see Table II). All patients with polyps fell into the categories of excellent, good, and mild, whereas no patient with polyps had been classified as severe or moderately severe.

Table II
Nasal Polyposis and Hearing Loss

Patient's General Condition and Shwachman Score	Exc. 86-100	Good 71-85	Mild 56-70	Mod. 41-55	Severe 40	Total
Study Group	4	11	7	3	1	26
Nasal Polyp	1	3	3	0	0	7
Conductive Hearing Loss	2	4	2	0	0	8
Coincidental Polyps and Hearing Loss	1	2	1	0	0	4

Paranasal Sinuses

Radiological studies of the paranasal sinuses were performed on all patients using standard techniques. Of the seventeen patients below the age of twelve years of age, only one, eight year old boy exhibited any development of frontal sinuses. Of the nine patients ranging in age from twelve to twenty years, two had well developed frontal sinuses; one had minimal frontal sinuses aeration, and six had no radiologic evidence of frontal sinus development. Thus agenesis or minimal development of the frontal sinuses was noted in all but two of the twenty-six patients studied.

Maxillary sinuses were well developed in all but four patients, three of whom were less than two years of age. However, in each case, opacification of the maxillary sinuses existed. This was bilateral in all cases, except one, and it is of interest that this child, a seven year old girl, was the only patient in the series who had significant symptoms which were interpreted clinically as being due to sinusitis.

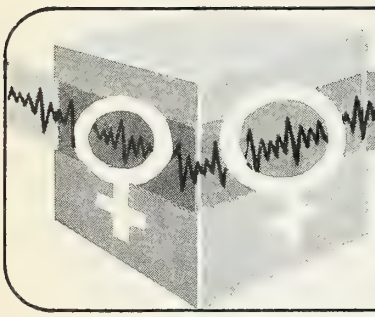
Clouding of the sphenoid and ethmoid sinuses was also demonstrated in most patients of the older age groups.

A relationship of the severity of paranasal sinus involvement to the severity of lung disease or general physical status was not demonstrated.

Bacteriology Studies

Nose and throat cultures were performed on all patients at each physician visit. Pseudomonas aeruginosa was cultured consistently from the throats of eighteen of the twenty-six patients, and in each case this was interpreted as a reflection of pseudomonas infection of the tracheo-bronchial tree, a well-known phenomenon in cystic fibrosis patients and probably ultimately inevitable in all cases.[5-7] This organism was also cultured from the nose in eight instances. In one instance, the nose culture alone revealed pseudomonas and this was the only instance in which the organism was not found on repeated cultures. Other pathogenic organisms, such as staphylococcus, hemolytic streptococcus, meningococcus and menophylus influenzae were found in nose and throat cultures but probably reflect findings that could be anticipated in this age group. No correlation existed between the severity of local findings and the presence or absence of pseudomonas.

(Continued on page 474)



pulse... of the doctor's wife

Mrs. Harold Keegan, Editor

October is Immunization Action Month

Condolences are extended to Mrs. William MacLean (Grace) daughter of Mrs. G. Henry Mundt, Sr., of Chicago, our 1st ISMS Auxiliary President (1927-1929); to the family of Mrs. Fred Endres, of Edward, ISMS Auxiliary President (1958-1959); and Mrs. Donald Rager on the death of her mother, Mrs. William Jarrell of Peoria.

Announcement – "A Confluence for Health"
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Dates to Note:

October—"Immunization Month"

Oct. 12-15	*AMA Auxiliary Conference* Drake Hotel, Chicago
Oct. 16	*District 1A Meeting* Ramada Inn, Rockford
Oct. 28	*District 4 Meeting* Swangataha Country Club, Galesburg
Nov. 6	*District 9-10 Meeting* Belleville
Nov. 11	*District 3 Meeting* Chicago
Nov. 12	ISMS and ISMS Auxiliary "Conference for Health" 8 a.m.-3:45 p.m., LaSalle Hotel, Chicago
Nov. 30-Dec. 5	*AMA Clinical Conference* Sheraton Waikiki Hotel, Honolulu
Jan. 15, 1976	*"Winter Board Meeting"* Arlington Park Hilton Hotel

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April 25-29, 1976 Palmer House, Chicago

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The first Afghan Raffle Tickets were available for the conference members and to take back to the counties. Mrs. Selig Hodes (Evelyn, 400 W. Willow, Forreston 61030), AMA-ERF State Vice Chairman is in charge of this AMA-ERF fund raising project which features two afghans and a pillow to be given away during the 1976 State Convention.

For details on the conference see the October "Pulse."

Cystic Fibrosis

(Continued from page 471)

Conclusions

Twenty-six patients with cystic fibrosis all exhibited disease of the paranasal sinuses, consisting of opacification of the maxillary sinuses either alone or as part of a parasinusitis. Symptoms of sinusitis seldom occurred and treatment was not generally required. Agenesis or delayed development of frontal sinuses was also seen in the majority of patients.

Nasal polyps occurred in 27% of the patients, all of whom were over five years of age. Excluding those patients under five years of age, none of whom had polyps, the incidence was 36%. In general, polyps were not observed in those patients with severe disease.

Mild degrees of conductive hearing loss were noted in the younger age groups especially, but no instance of severe hearing loss or nerve conduction disturbance was encountered. Such mild degrees of hearing loss may merely reflect the application of standards too stringent for this age group.[8]

Throat and nose cultures on 26 patients revealed pseudomonas aeruginosa in eighteen cases, reflecting the flora of the tracheobronchial tree. Other organisms were encountered on an unpredictable basis with findings consistent with those anticipated in this age group of patients.

Discussion

The otolaryngological aspects of cystic fibrosis are dominated by involvement of the paranasal sinuses manifest as delayed development of frontal sinuses and opacification of maxillary, sphenoid and ethmoid sinuses as well as a high incidence of nasal polyposis.[9] In this series, the sinus involvement was not suspected on clinical grounds which seems to contrast with the experience of Pennington who stated that patients were usually seen by the otolaryngologist because of nasal suppuration and obstruction.[10] It is possible that this apparent contradiction might be explained on the basis of the prospective nature of present studies and the fact that all patients were being treated before and during the study period. The fact that in the present series, the invariable finding of staphylococcus aureus on culture could not be duplicated tends to support this contention.

The high incidence of nasal polyposis is stressed in this report together with the observation that polyps are more likely to occur in older patients in whom the general and pulmonary status is less severe than average. The fact that polyps were not encountered in the most severely involved patients may be an effect of therapy since those with severe chest disease received intensive antibiotic therapy in all cases. Shwachman and co-workers noted that the effect of broad sputum antibiotics on the regrowth of polyps was "impressive." Polyps may be entirely asymptomatic for long periods of time in some patients, but in others, symptoms of obstruction may justify polypectomy.

Significant hearing loss, either conductive or sensori-neural, is not a feature of cystic fibrosis. Mild conductive loss as seen in many patients in the younger age groups as reported in this and previous studies,[9,12] is a common finding which has little if any social or educational significance. ◄

References

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Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

AURORA—Board eligible or certified gynecologist to join established corporation in town of 75,000—30 miles west of Chicago. Guaranteed salary 1st year with partnership arrangements thereafter. Option to buy in anytime. G. J. Shimkus, M.D., 143 So. Lincoln Ave., Aurora, 60505. 312-896-7892. (1)

BELLEVILLE: Pulmonary Disease Specialist—Part Time Director wanted for modern 329 bed full service community hospital with extensive building program. Complete specialty backup. 500,000 served by local hospitals. No pulmonary specialist in hospital or private practice. Contact: Matthew Eisele, M.D., Memorial Hosital, 4501 North Park Drive, Belleville, 62223. (618) 233-7750, Ext. 345 (11)

BELLEVILLE: Emergency Medical Services Director wanted for modern 329 bed full service community hospital. Areawide Trauma Center. Emergency Department expanding to 10,900 square feet. Full time physician coverage since January, 1971. Complete specialty backup. Financial arrangements negotiable. Contact: Matthew Eisele, M.D., Memorial Hospital, 4501 North Park Drive, Belleville, 62223. (618) 233-7750, Ext. 345. (11)

CHICAGO: Medical Center N.W. Side of Chicago with clinical laboratory, X-rays, physical therapy. 2 Family Physicians, members A.A.P.F., looking for a young, well trained, ambitious F.P. Privileges in hospital with Department of Family Practice, F. S. Steinitz, M.D., 3653 W. Lawrence, Chgo. 60625 (312-478-6000). (12)

CHICAGO: Physician needed for well established, ultra modern medical center. Full laboratory and X-ray. Congenial working conditions and excellent co-workers. Good hospital associations. No evenings or weekends. Clinic located south side, near lake. Contact Mr. Lawrence, Booker Family Health Care Center, 747 E. 47th, Chicago, 60653, (312) 624-4800. (1)

DIXON: Internist-Pediatrician-Orthopedic Surgeon-board certified/board eligible. Well established multi-specialty clinic, closely affiliated with a 200 bed hospital, offers opportunities to build a large practice in these specialties. Progressive community, within ninety miles of Chicago, offers a unique family oriented environment. No traffic problems, clean air, and excellent recreation areas combine to provide the "good life." Only 45 minutes from Rockford, allows easy access and exposure to academic medicine. Phone collect—John Tatum, Administrator, Medical Arts Clinic, Dixon, 61021. (815) 288-5531. (3)

HARDIN: Doctor wanted to work in modern three doctor medical center presently staffed with one doctor. Laboratory and x-ray equipment available. New ambulance which is manned by 50 trained EMTA volunteers. Hospital nearby. Located in beautiful Calhoun County Illinois between the Mississippi and Illinois rivers within one hour drive of St. Louis. Excellent hunting and fishing facilities. Contact: Calhoun County Farm Bureau, Hardin, Illinois 62047. Phone 618-576-2233. (3)

HARVEY: Pleasant moderate-sized general practice with full lab, expert clerical staff and list of consultants in Chicago south suburbs with modern hospital nearby. Full or part-time M.D.'s desired. Competitive salary negotiable, with benefits, flexible schedule and other valuable considerations, as office is expanding. Good opportunity for right doctors. Contact: Mrs. Wynne, 14734 Oakley, Harvey, (312) 331-8000 (3)

KANKAKEE: Emergency Room Physician, Board eligible or certified preferred, needed for 300 bed acute care hospital in Chicago area. Liberal fringe benefits. Contact Raymond Malott, M.D., St. Mary's Hospital, 500 West Court Street, Kankakee 60901. Phone (815) 939-4111. (3)

McHENRY: Immediate openings for General Internist, Cardiologist, Cardio-Vascular and Thoracic Surgeon, Urologist and Orthopedic Surgeon. Outstanding opportunity to join multi-specialty group in mid-west resort area near Chicago. Salary with incentive from day one: fringe benefits and unusually good income potential. Group building directly connected to 143 bed community hospital. Contact: Ted L. Rolander, M.D., McHenry Medical Group, 1110 N. Green St., McHenry, 60050 or (815-385-1050) (3)

NAPERVILLE: Emergency Department Physicians wanted full time! For busy E.R. in a 154-bed growing hospital located in beautiful residential suburb 40 miles west of Chicago. Career-service oriented. ACEP membership preferred. All shifts to rotate. Full back-up coverage. Excellent fringe benefits package. Spacious new Emergency Department with EMS and MICU programs developing! Volume about 20,000 patient visits annually. Curriculum vitae and salary requirements first letter. Contact Dr. A. Albrecht, E.R. Director, Edward Hospital, Naperville, 60540, or call (312) 355-0450.

ROUND LAKE: Family Practitioner needed in a growth community. Complete office facility available, due to recent death of GP. Family and Industrial practice—drawing population 25,000. Location North Eastern area, centered between Chicago and Milwaukee. Three hospital affiliation—fully accredited—total 954 beds. Excellent opportunity. All recreational facilities nearby. Contact: Doris Brundza, POB 488, Round Lake 60073, 312-546-4623 (11)

VANDALIA: Population 6,000. Family physicians needed. Office space available. Hospital with 100 beds, all services. An excellent school system and all denominations of churches. One hour from St. Louis on the interstate highway. Local lake for boating and fishing, close to the Carlyle Lake. Recreational facilities. Contact: D. H. Rames, M.D., 1029 N. 8th St., Vandalia, 62471 (618-283-3012) or Larry Harrison, Administrator, Fayette County Hospital, Vandalia, 62471 (618-283-1231). (12)

WEST DUNDEE: Small town—45 miles NW from Chicago by Tollroad—Active, well established Family Practice—Large drawing area—Only 1 other physician in town—2 large modern hospitals nearby—Office, equipment and residence available (Rental, sale or financing) —Martin C. Koenig, M.D., 118 N. 3rd, West Dundee 60118. Call (312) 428-6725 or 426-2600 (12)

ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110

Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

NOVEMBER, 1975

Anesthesia

ANESTHESIOLOGY CONFERENCE
For: Anesthesiologists. 2-Day Lecture Course. Nov. 7-8. Ann Arbor, Mich. **CME Credit:** AMA Cat. 1. **Fee:** $60. **Sponsor, contact:** Office of Intramural Ed., Dept. of Postgrad. Med. & Health Professions Ed., G1109 Towsley Center, U. of M., Ann Arbor, Mich. 48104.

ANESTHESIA FOR HEAD AND NECK SURGERY
For: All MDs 3-Day Course. Nov. 20-22. Chgo. **CME Credit:** 22 hrs. AMA Cat. 1. **Fee:** $250. **Reg. Limit:** 50. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

CME Planning

IDENTIFYING CME NEEDS THROUGH MEDICAL AUDIT
For: Hospital DME's; Program Chairmen, Medical Faculty, CME Planners. Weekend Workshop. Nov. 21-23. Oak Brook Hyatt House. **CME Credit:** 14 hrs. AMA Cat. 1. **Fee:** $160. **Reg. Limit:** 20. **Reg. Deadline:** Nov. 7. **Sponsor, Contact:** ICCME, 55 E. Monroe, Chicago, Ill. 60603. Attention: Dr. Leonard Stein, Executive Director.

Emergency Care

ANNUAL MEETING OF THE MICHIGAN STATE MEDICAL SOCIETY
For: FPs and Emergency Med. Specialty. Lectures. Nov. 11. Southfield, Mich. **CME Credit:** 5 hrs. AMA Cat. 1; ACEP, **Fee:** none. **Reg. Limit:** 300. **Co-Sponsors:** Michigan State Med. Soc. and Michigan Chapter, Am. Coll. of Emergency Physicians. **Contact:** Michigan State Medical Society, 120 E. Saginaw, East Lansing, Mich. 48823.

Family Medicine

CARDIOLOGY IN FAMILY MEDICINE
For: FPs and Internists. 3-Day Lecture/Workshop. Nov. 3-5. Ann Arbor, Mich. **CME Credit:** AMA Cat. 1; AAFP Prescribed. **Fee:** $150. **Sponsor, contact:** Office of Intramural Ed., Dept. of Postgrad. Med. & Health Professions Ed., G1109 Towsley Center, U. of M., Ann Arbor, Mich. 48104.

PSYCHIATRY FOR THE MEDICAL PRACTITIONER
For: All MDs. 3-Day Course. Nov. 5-7. Chgo. **CME Credit:** 24 hrs. AMA Cat. 1. **Fee:** $175. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

UROLOGY FOR THE GENERAL PRACTITIONER
For: FPs. 2-Day Course. Nov. 13-14. Chgo. **CME Credit:** 16 hrs. AMA Cat. 1. **Fee:** $75. **Reg. Limit:** 50. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

FAMILY PRACTICE TOPICS
For: FPs. One-Day Lecture/Workshop. Nov. 22. Ann Arbor, Mich. **CME Credit:** AMA Cat. 1. **Fee:** none. **Sponsor, contact:** Office of Intramural Ed., Dept. of Postgrad. Med. & Health Professions Ed., G1109 Towsley Center, U. of M., Ann Arbor, Mich. 48104.

Gynecology

ANNUAL POST-GRADUATE ASSEMBLY OF SOUTHERN ILLINOIS MEDICAL ASSOCIATION
For: All MD's. Annual Post-Graduate Meeting. Nov. 6, 1975. Belleville. **Speaker:** Clement J. Sullivan, M.D. **CME Credit:** 4 Hrs. AMA Cat. 1. **Sponsor, contact:** Southern Illinois Medical Association, 109 S. High St., Belleville, IL 62220. Att'n: W. H. Walton, M.D.

Internal Medicine

ADVANCES IN MEDICINE
For: Internists. 5-Day Course. Nov. 17-21. Chgo. **CME Credit:** 35 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 50. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago 60612.

Laryngology

COURSE IN LARYNGOLOGY AND BRONCHOESOPHAGOLOGY
For: Physicians or Residents in Otolaryngology. 6-Day Course. Nov. 3-8. Chgo. **Fee:** $350. **Reg. Limit:** 20. **Sponsor, contact:** U. of Ill. Abraham Lincoln School of Med., 1855 W. Taylor St., Chicago, Ill. 60612. Att'n: Marion B. Wickland.

Medical Audit

PAS TUTORIAL
For: MDs, Hospital Administrators, Health Record Analysts, Chiefs of Medical Records. 2-Day Course. **Speaker:** Vergil N. Slee, MD, Pres. CPNA. Nov. 5-6. Ann Arbor, Mich. **CME Credit:** 12 hrs. AMA Cat. 1; AAFP Elective; AOA Cat. 2-0; ACGOPMS-Class 2. **Fee:** $135 per 3 registrants from a hospital. **Reg. deadline:** 10 days prior. **Sponsor, contact:** Commission on Professional and Hospital Activities, 1968 Green Rd., Ann Arbor, Mich. 48105. Att'n: Ione B. Rhodes.

MEDICAL AUDIT PROCEDURE SEMINAR/WORKSHOP
For: Medical Records Staff and MDs. 3-Day Seminar/Workshop. Nov. 5-7. Chgo. **CME Credit:** 14 hrs. AMA Cat. 1; 16 hrs. AMRA. **Fee:** $150. **Reg. Limit:** 50. **Reg Deadline:** 1 week prior. **Sponsor: contact:** Joint Comm. on Accreditation of Hospitals, 875 N. Michigan, Chicago, 60611. Att'n: Laurie Kidd.

MEDICAL AUDIT TEAM SEMINAR (ADVANCED)
For: Medical Records Staff and MDs. 3-Day Seminar. Nov. 19-21. Chgo. **CME Credit:** 14 hrs. AMA Cat. 1; **Fee:** $150. **Reg. Limit:** 50. **Reg. Deadline:** 1 week prior. **Sponsor, contact:** Joint Comm. on Accreditation of Hospitals, 875 N. Michigan, Chicago 60611. Att'n: Laurie Kidd.

Medicine

TUBLO INTERSTITIAL RENAL DISEASE
For: MDs and Nurses. Lecture. **Speaker:** Wadi N. Suki, MD, Baylor College, Houston, Tex. Nov. 5. **CME Credit:** 1 hr. AMA Cat. 1. AAFP. **Fee:** none. **Sponsor, contact:** Martha Washington Hospital, 4055 N. Western Ave., Chicago, Ill. 60618. Att'n: Fernando Lopez-Fernandez, MD.

THE MANAGEMENT OF BREAST CANCER
For: Physicians. Group Discussions and Lecture. Nov. 7-8 **Speaker:** Dr. Sheldon Kaufman, Massachusetts General Hospital, Chgo. **CME Credit:** 5 hrs. AMA Cat. 1. **Fee:** $10 (dinner only). **Reg. Deadline:** Nov. 3 (dinner only). **Sponsor, contact:** FAB3/CME, Belmont Community Hospital, Chicago. Att'n: John McCracken.

SPECIAL SCIENTIFIC PROGRAM HONORING DR. LEON O. JACOBSON
For: All physicians. Symposium. Nov. 8, 1975. Billings Hospital, Chicago. **Co-Sponsors:** Univ. of Chicago Div. of Biological Sciences and Pritzker School of Medicine. **Contact:** Office of the Dean, 950 E. 59th St., Chicago, IL 60637.

FRONTIERS OF EMERGENCY MEDICINE
For: All MDs. Lecture. **Speaker:** Peter Rosen, MD, Professor of Emergency Medicine. Nov. 12. Chicago. **CME Credit:** 3 hrs. AMA Cat. 1. AAFP. **Fee:** $20. **Reg. Limit:** 250. **Sponsor, Contact:** University of Chicago, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago, Ill. 60637. Attention. Mrs. Elaine Ehrman.

Musculoskeletal Trauma

CLINICAL HOSPITAL PROGRAM ON MUSCULOSKELETAL TRAUMA
For: All physicians, residents, interns. 2-Hour Evening Clinical Program. Nov. 18. Des Plaines. **CME Credit:** 2 hrs. AMA Cat. 1; AAFP. **Sponsor, contact:** Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. Att'n: Mrs. Lillian Husa.

Neurology

FOURTH ANNUAL CLINICAL NEURO-OPHTHALMOLOGY
For: Ophthalmologists, Neurologists. Symposium. Nov. 12. Indiana. **CME Credit:** 6 hrs. AMA Cat. 1. **Fee:** $35. **Sponsor, Contact:** Indiana Univ. School of Med., Div. of CME, 1100 W. Michigan St., Indianapolis, Ind. 46202. John Roscoe, Assistant Director.

Nursing Audit

NURSING AUDIT WORKSHOP
For: Nurses. 3-Day Workshop. Nov. 12-14. Chgo. **Fee:** $150. **Reg. Limit:** 50. **Reg. Deadline:** Nov. 5. **Sponsor, contact:** Joint Comm. on Accreditation of Hospitals, 875 N. Michigan, Chicago, 60611. Att'n: Laurie Kidd.

Obstetrics/Gynecology

WHAT'S NEW IN OB-GYN?
For: All MDs. Symposium. Nov. 19-20. Indianapolis. **CME Credit:** 12 hrs. AMA Cat. 1. AAFP. **Fee:** $50. **Sponsor, Contact:** Indiana Univ. of Med. Div. of CME, 1100 W. Michigan St., Indianapolis, Ind. 46202. John Roscoe, Assistant Director.

Oncology

SYMPOSIUM ON LYMPHOMAS
For: All MDs. Symposium. Nov. 5. Indianapolis. **CME Credit:** 6 hrs. AMA Cat. 1. **Fee:** $35. **Co-Sponsors:** Marion County Cancer Society and Indiana Univ. School of Med. **Contact:** Indiana Univ. School of Med., Div. of CME, 1100 W. Michigan St., Indianapolis, Ind. 46202. John Roscoe, Assistant Director.

MODERN RADIOTHERAPY IN CANCER MANAGEMENT
For: MDs, Nurses, Paramedics. Seminar. **Speaker:** Dr. Wagih Shehata. Nov. 25. Elmhurst, Ill. **CME Credit:** 1 hr. AMA Cat. 1. **Sponsor, Contact:** Memorial Hospital of DuPage County, Avon & Schiller, Elmhurst, Ill. 60126. John H. Huss, MD, Director of Medical Education.

Ophthalmology

CONTACT LENS SEMINAR
For: Ophthalmologists. Symposium. Nov. 19. Indianapolis. **CME Credit:** 6 hrs. AMA Cat. 1. **Fee:** $35. **Sponsor, Contact:** Indiana Univ. School of Med., Div. of CME, 1100 W. Michigan St., Indianapolis, Ind. 46202. John Roscoe, Assistant Director.

Otorhinolaryngology

ANNUAL OTOLARYNGOLOGIC ASSEMBLY
For: Otolaryngologists. Nov. 8-14, Chgo. **CME Credit:** 40 Hrs.. AMA Cat. 2. **Fee:** $350. **Sponsor, contact:** U. of Ill. Abraham Lincoln School of Med., 1855 W. Taylor St., Chicago, Ill. 60612. Att'n: Marion B. Wickland.

Pediatric Cardiology

HYPERTENSION IN CHILDHOOD
For: All MDs, Nurses, Paramedics. Seminar. **Speaker:** Dr. Sachchida Sinha, Loyola Stritch School of Med. Nov. 11. Elmhurst, Ill. **CME Credit:** 1 hr. AMA Cat. 1. **Fee:** None. **Sponsor, Contact:** Memorial Hospital of DuPage County, Avon & Schiller, Elmhurst, Ill. 60126. John H. Huss, MD, Director of Medical Education.

Pediatrics

GENERAL PEDIATRICS
For: GPs. 5-Day Course. Nov. 10-14. Chgo. **CME Credit:** 35 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 70. **Sponsor, contact:** Cook County Grad. School of Medicine, 707 S. Wood St., Chicago, 60612.

TALL CHILD/SHORT CHILD
For: Pediatricians. Monthly lecture/dinner program. Nov. 18, 8:00 PM. Downtown Holiday Inn, Chicago. **Speaker:** Dr. Allen Root. **Sponsor, contact:** Chicago Pediatric Society, 2800 W. 87th St., Chicago, IL 60652. Att'n: Thomas P. Driscoll.

Plastic Surgery

MANAGEMENT OF SKIN TUMORS
For: MDs, paramedics, students. Seminar. Nov. 4. Elmhurst. **CME Credit:** 1 hr. AMA Cat. 1. **Fee:** None. **Sponsor, contact:** Memorial Hospital of DuPage County, Avon & Schiller, Elmhurst, Ill. 60126. Att'n: John H. Huss, M.D.

Professional Liability

ONE-DAY WORKSHOP
For: MDs, Attorneys, Hospital Administrators. **Speaker:** Roger O. Egeberg, M.D. Nov. 7. Hyatt-Regency, Chicago. **Fee:** $40-members; $45-non-members. **Sponsor, contact:** Institute of Medicine of Chicago, 332 S. Michigan Ave., Chicago, Ill. 60604.

Psychiatry

LECTURE SERIES: PAIN AND ANGST AND THEIR ALLEVIATION
For: Physicians and Mental Health Professionals. Series: Sept. '75-April '76. Nov. 5. "Acupuncture and Acupush." **Speaker:** Stephen T. Botek, M.D. Instructor of Psychiatry, New York Med. **Fee:** $90 (entire series); $15 (ind. lecture). **CME Credit:** 2 hrs. AMA Cat. 1. AAFP Elective. **Co-Sponsors:** Forest Hospital Foundation and Chicago Medical School. **Contact:** Forest Hospital, 555 Wilson Lane, Des Plaines, Ill. 60016.

RECENT ADVANCES IN PSYCHIATRY
For: Psychiatrists. 5-Day Course. Nov. 10-14. Chgo. **CME Credit:** 39½ hrs. **Fee:** $200. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Grad. School of Med., 707 S. Wood St., Chicago, Ill. 60612.

FINANCING PSYCHIATRIC SERVICES
For: Psychiatrists. Distinguished Lecture Series. **Speaker:** Walter Barton, MD, Dartmouth Med. School. Nov. 19. Chgo. **CME Credit:** 1½ hrs. AMA Cat. 1. **Fee:** None. **Sponsor, contact:** Institute of Psychiatry. Northwestern U. Med. School, 320 E. Huron St., Chicago, Ill. 60611. Att'n: Dr. Barbara A. Kay.

Psychotherapy

BRIEF PSYCHOTHERAPEUTIC INTERVENTIONS
For: Mental Health Professionals. Symposium. Nov. 19, 1:00-4:00 PM, Forest Park. **Speaker:** Paul Watzlawick, Ph.D. **Fee:** $10. **Reg. Limit:** 204. **Reg. Deadline:** Reservations Req. **Sponsor, contact:** Riveredge Hospital Foundation, 8311 W. Roosevelt Rd., Forest Park, IL 60130. Att'n: John Pontarelli.

Surgery

SPECIALTY REVIEW COURSE IN GENERAL SURGERY
For: Surgeons. 10½ Day Course. Nov. 3-14. Chgo. **CME Credit:** 94 hrs. AMA Cat. 1. **Fee:** $400. **Reg. Limit:** 350. **Sponsor, contact:** Cook County Grad. School of Med., 707 S. Wood St., Chicago, Ill. 60612.

Surgery and Medicine

SEMINAR ON SURGERY AND MEDICINE FOR LAKE COUNTY
For: All MD's. Nov. 19, 1975. St. Therese Hospital, Waukegan. **CME Credit:** 5 Hrs. AMA Cat. 1. **Reg. Deadline:** Nov. 16. **Sponsor, contact:** St. Therese Hospital, 2615 W. Washington, Waukegan, IL 60085. Att'n: R. M. Adelman, D.D.S., M.D.

Radiology

RUSH MEDICAL COLLEGE COURSE ON COMPUTED TOMOGRAPHY
For: Radiologists, Neurologists, Neurosurgeons. Nov. 6. Chicago. **CME Credit:** 11 hrs. American College of Radiology, Cat. 1. **Fee:** $175. **Reg. Limit:** 200. **Co-Sponsors:** American College of Radiology and Rush Medical Co'lege. **Contact:** Department of Diagnostic Radiology, Presbyterian-St. Lukes Hospital, Chicago, Ill. 60612. Attention: Michael S. Huckman, MD.

Trauma

CLINICAL HOSPITAL PROGRAM ON MUSCULOSKELETAL TRAUMA
For: All MDs, Residents and Interns. 2-Hour Evening Clinical Program. Nov. 17. DesPlaines, Ill. **CME Credit:** 2 hrs. AMA Cat. 1; AAFP. **Fee:** none. **Sponsor, contact:** Chicago Committee on Trauma/American College of Surgeons, 11255 W. 74th St., LaGrange, Ill. 60525.

December, 1975

Antibiotics

UPDATE ON ANTIBIOTICS
For: Pediatricians. Monthly lecture/dinner program. Dec. 16. 8:00 PM. Downtown Holiday Inn, Chicago. **Speaker:** Dr. Pierce Gardner. **Sponsor, contact:** Chicago Pediatric Society, 2800 W. 87th St., Chicago, IL 60652. Att'n: Thomas P. Driscoll.

Endocrinology

AMENORREA: CAUSES AND TREATMENT
For: All MDs. Lecture. **Speaker:** Robert L. Rosenfeld, MD, Assoc. Prof. of Pediatrics, Univ. of Chicago. Dec. 2. Highland Park, Ill. **Fee:** None. **Sponsor, Contact:** Highland Park Hospital, 718 Glenview Ave., Highland Park, Ill. 60035. Attention: Mrs. Susan Stuttle.

Family Medicine

COMPLICATIONS OF THE PILL AND IUD
For: All physicians. Group Discussion and Lecture. Dec. 3-4. Dec. 3: 10 AM, Thorek Medical Center; 6:00 PM, Lincolnwood Hyatt House; Dec. 4: 10 AM, Bethesda Hospital. **Speaker:** Dr. Carolyn B. Coulam, Mayo Clinic. **CME Credit:** 5 Hrs. AMA Category 1. **Fee:** $10 (other than Staff for dinner). **Reg. Deadline:** Nov. 29 (dinner only). **Sponsor:** FAB^3/CME. **Contact:** Thorek Medical Center, 850 W. Irving Park Road, Chicago, IL 60613. Att'n: Mr. Peter Pierdinock.

ACUTE CARDIAC CARE
For: All MDs. 3-Day Course. Dec. 3-5. Chicago. **CME Credit:** 21 hrs. AMA Cat. 1. **Fee:** $125. **Reg. Limit:** 80. **Sponsor, Contact:** Cook County Grad. School of Med., 707 S. Wood St., Chicago, Ill. 60612.

BASIC OBSTETRICS
For: All MDs. 5-Day Course. Dec. 1-5. Chicago. **CME Credit:** 35 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 50. **Sponsor, Contact:** Cook County Grad. School of Med., 707 S. Wood St., Chicago, Ill. 60612.

General Medicine

INTENSIVE CORONARY CARE
For: Physicians, Nurses, Paramedics. Seminar. **Speaker:** Dr. J. P. Stokes, Mayo Clinic. Dec. 2. Elmhurst, Ill. **CME Credit:** 1 hr. AMA Cat. 1. **Fee:** None. **Sponsor, Contact:** Memorial Hospital of DuPage County, Avon & Schiller, Elmhurst, Ill. 60126. John H. Huss, MD, Director of Medical Education.

GASTROINTESTINAL EMERGENCIES—SURGICAL AND MEDICAL
For: All MDs. Symposium. Dec. 4. Richmond, Indiana. **CME Credit:** 6 hrs. AMA Cat. 1. **Fee:** $35. **Sponsor, Contact:** Indiana Univ. School of Med., Div. of CME, 1100 W. Michigan St., Indianapolis, Ind. 46202. John Roscoe, Assistant Director.

Internal Medicine

ADVANCES IN THE DIAGNOSIS AND MANAGEMENT OF HYPERTENSION
For: All MDs. Lecture. **Speaker:** Suzanne Oparil, MD, Assoc. Prof. Dept. of Med. Dec. 10. Chicago. **CME Credit:** 3 hrs. AMA Cat. 1; AAFP Elective. **Fee:** $20. **Sponsor, Contact:** Univ. of Chicago, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago, Ill. 60637. Attention: Mrs. Elaine Ehrman.

Orthopedics

ORTHOPEDIC PROBLEMS OF THE NEWBORN
For: Pediatricians. Monthly lecture (dinner meeting). Dec. 16, 1975. Downtown Holiday Inn, Chicago. **Speaker:** Dr. Jack Davis. **Sponsor, contact:** Chicago Pediatric Society, 121 W. 154th St., Harvey, IL 60426. Att'n: Lowell M. Zollar, M.D.

Pediatrics

CURRENT PEDIATRIC MANAGEMENT
For: Ped, FP, GPs. Symposium. Dec. 3. Indianapolis. **CME Credit:** 6 hrs. AMA Cat. 1. **Fee:** $35. **Sponsor, Contact:** Indiana Univ. School of Med., Div. of CME, 1100 W. Michigan St., Indianapolis, Ind. 46202. John Roscoe, Assistant Director.

Psychiatry

THE PRIVATE SECTOR OF MENTAL HEALTH SERVICES PRESENT AND FUTURE
For: Psychiatrists. Lecture. **Speaker:** Jacob Fishman, MD, Pres. of American Health Services, Inc. Dec. 17. Chicago. **Fee:** None. **Sponsor, Contact:** Institute of Psychiatry, Northwestern Med. School, 320 E. Huron St., Chicago, Ill. 60611. Attention: Dr Barbara A. Kay.

The *American Society for Clinical Pharmacology and Therapeutics* offers a Continuing Medical Education Program directed toward the practicing physician. Speakers are available from the Society's excellent speaker's bureau. Contact: Elaine Galasso, 1718 Gallagher Rd., Norristown, PA 19401.

Psychotherapy

THE RATIONAL-EMOTIVE APPROACH TO THERAPY
For: Mental Health Treatment Professionals. Symposium. Dec. 17, 1:00-4:00 PM, Forest Park. **Speaker:** Albert Ellis, Ph.D. **Fee:** $10. **Reg. Limit:** 204. **Reg. Deadline:** Reservations Req. **Sponsor, Contact:** Riveredge Hospital Foundation, 8311 W. Roosevelt Road, Forest Park, IL 60130. Att'n: John Pontarelli.

Surgery

HAND SURGERY—THE STATE OF THE ART
For: Orthopedic Surg.; Surgical Residents; Industrial Surg. Three-Day Course. Dr. Robert R. Schenck, Course Chairman. Dec. 4-6. Chicago. **CME Credit:** 16 hrs. AMA Cat. 2; AAFP Elective. **Fee:** $200. $100 (Residents). **Co-Sponsors:** Rush-Presbyterian St. Luke's Medical Center and American Society for Surgery of the Hand. **Contact:** Robert R. Schenck, MD, 1725 W. Harrison St., Suite 33, Chicago, Ill. 60612.

SPECIALTY REVIEW COURSE IN GENERAL SURGERY, PART II
For: Surgeons. 11-Day Course. Dec. 1-12. Chicago. **CME Credit:** 99 hrs. AMA Cat. 1. **Fee:** $400. **Reg. Limit:** 150. **Sponsor, Contact:** Cook County Grad. School of Med., 707 S. Wood St., Chicago, Ill. 60612.

Urology

SPECIALTY REVIEW COURSE IN UROLOGIC PATHOLOGY & X-RAY
For: Urologists. 2½ Day Course. Dec. 4-6. Chicago. **CME Credit:** 20 hrs. AMA Cat. 1. **Fee:** $100. **Reg. Limit:** 75. **Sponsor, Contact:** Cook County Grad. School of Med., 707 S. Wood St., Chicago, Ill. 60612.

January, 1976

Endocrinology

FUNCTIONING AND NON-FUNCTIONING TUMORS OF THE PITUITARY
For: All physicians. Lecture. Jan. 20, 1976. 8:00 PM. Highland Park Hospital. **Speaker:** Raymond V. Randall, M.D., Mayo Clinic. **Reg. Limit:** 70. **Reg. Deadline:** Jan. 15. **Sponsor, contact:** Highland Park Hospital, 718 Glenview Ave., Highland Park, IL 60035. Att'n: Mrs. Susan Struttle, Admin. Secy.

General Medicine

MODERN MANAGEMENT OF DISEASES OF THE LUNG
For: All physicians. Symposium. Jan. 15, 1976, Richmond, Indiana. **CME Credit:** 6 Hrs. AMA Cat. 1. **Fee:** $35. **Sponsor, contact:** Indiana Univ. School of Med., Div. of Postgraduate & Cont. Med. Educ., 1100 W. Michigan St., Indianapolis 46202. Att'n: John Roscoe.

FIBEROPTIC COLONOSCOPY
For: All physicians. 3-day Course. Jan. 21-23. Chicago. **CME Credit:** 19 Hrs. AMA Cat. 1. **Fee:** $250. **Reg. Limit:** 10. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612.

Medicine

INFECTIOUS DISEASE
For: All physicians. Symposium. Jan. 21. Indianapolis. **CME Credit:** 6 Hrs. AMA Cat. 1. **Fee:** $35. **Sponsor, contact:** Indiana Univ. School of Medicine, Div. of Postgraduate & Cont. Med. Educ., 1100 W. Michigan St., Indianapolis 46202.

Otolaryngology

OTOLARYNGOLOGY WORKSHOP FOR THE FAMILY PRACTITIONER
For: FP, GP. Symposium, Jan. 29. Indianapolis. **CME Credit:** 7 Hrs. AMA Cat. 1; AAFP. **Fee:** $35. **Reg. Limit:** 42. **Sponsor, contact:** Indiana Univ. School of Medicine, Div. of Postgraduate & Cont. Med. Educ., 1100 W. Michigan St., Indianapolis 46202.

Psychiatry

EMPTINESS IN THE LIVES OF COMEDIANS
For: Physicians, Mental Health Professionals. Lecture. Jan. 7. 7:30-9:30 PM. Des Plaines. **Speaker:** Samuel S. Janus, Ph.D., NY Medical College. **CME Credit:** 2 Hrs. AMA Cat. 1, AAFP Elective. **Fee:** $15 (ind. lectures). **Reg. Limit:** 120. **Co-sponsors:** Chicago Medical School, Dept. of Psychiatry and Forest Hospital Foundation. **Contact:** Forest Hospital, 555 Wilson Lane, Des Plaines, IL 60016.

THE KEY CONFERENCE AND THE FUTURE OF THE AMERICAN PSYCHIATRIC ASSOCIATION
For: Psychiatrists. Lecture. Jan. 21. 8:00 PM. Passavant Hosp., Chicago. **Speaker:** Melvin Sabsin, M.D., American Psychiatric Association. **CME Credit:** 1½ Hrs. AMA Cat. 1. **Sponsor, contact:** Institute of Psychiatry, Northwestern U. Med. School, 320 E. Huron St., Chicago 60611.

Surgery

FIBEROPTIC ESOPHAGOGASTRIC ENDOSCOPY
For: All physicians. 3-day Course. Jan. 26-28. Chicago. **CME Credit:** 19½ Hrs. AMA Cat. 1. **Fee:** $250. **Reg. Limit:** 10. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612.

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PSYCHIATRIST: Board eligible or board certified with license to practice in Illinois or ability to obtain license. Primary affiliation with multi-specialty medical clinic/hospital and contractual arrangement with community mental health center. This is an excellent opportunity in northwestern Illinois ninety miles west of metropolitan Chicago. Employment will involve psychiatric services to a network of community based programs as well as private practice. Job profile flexible to suit individual. Income and fringe benefits highly competitive. Contact Albert E. Graff, Executive Director, Sinnissippi Mental Health Center, Dixon-Sterling Freeway, Dixon, Illinois. Phone collect (815) 284-6611, or Contact John Tatum, Administrator, Medical Arts Clinic, 403 E. First Street, Dixon, Illinois 61021. Phone collect (815) 288-5531.

OB-GYN and UROLOGY specialties to join an established successful practice with 16-man multi-specialty group. Excellent group benefits; retirement plan; modern clinic facilities; progressive community with excellent educational system including two colleges; area population 75,000; great recreational facilities; must be board eligible or certified; Contact: Business Manager, The Manitowoc Clinic, 601 Reed Avenue, Manitowoc, Wisconsin 54220.

BOLINGBROOK-ROMEOVILLE-WOODRIDGE. Total poulation 70,000. Only six Doctors and four Dentists covering this area. Urgent need for additional help. For Association or solo contact: Bolingbrook Professional Building, 519 E. Briarcliff Rd, Bolingbrook, Illinois. 60439 (312-739-5121).

FOURTH MAN NEEDED FOR OB-GYN PRACTICE Two Hospitals-Each 8 minutes from office. Three man rotation of nite call and weekends. Office hours: Mon., Tues., Thurs., 2 to 7, Fri., 11 to 1:30. Good salary, and benefits: pension fund & profit sharing. Opportunity for involvement in 25-35 man multispecialty. Group with attached surgical center and ultimate adjoining hospital. Call Elliott I. Breslar 312-935-6969.

ANESTHESIOLOGIST—WANTED Board Certified or eligible to join South Suburban Chicago group servicing progressive 500 bed community hospital; Excellent income; Malpractice insurance available. Send CV in confidence to Box 857 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, Ill. 60603.

CARDIOLOGISTS wanted on a part-time basis for the interpretation and serial comparison of ECGs. Experience with interpretation of Holter recordings is also desirable. Please apply in writing to: Dr. Louis C. Lax, c/o TELEMED Corporation, 2345 Pembroke Ave., Hoffman Estates, Illinois, 60172; or phone (312) 884-0900.

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INTERNIST AND PEDIATRICIAN—Immediate opening—5-man multispecialty group needs third internist and second pediatrician. Group includes Gen. Surgeon and OB-Gynecologist, all Board Certified. Located next door to Community Hospital with recently completed additional primary care facilities. Community close to Metro-Milwaukee and two hours from Metro-Chicago. First year salary open. Excellent fringes including approved profit-sharing plan. Contact J. L. Algiers, M.D. (Int.) or P. M. Donahue, M.D., (Ped.) or Clinic Manager at Parkview Medical Associates, Ltd., 1004 East Sumner St., Hartford, WI 53027 or collect 414-673-5745.

CONSULTANT PSYCHIATRIST to work full or part time performing diagnostic evaluations on children and adolescents for the Cook County Juvenile Court. Experience with latency age and/or adolescent children required. Personnel Section, 1100 South Hamilton Avenue, Chicago 60602, 633-2268.

PROGRAM DIRECTOR—FAMILY PRACTICE: 809 bed teaching hospital located in suburban Chicago area is seeking a Family Practitioner to direct an existing approved residency program. Modern Model Family Practice Unit with an area of 14,000 sq. ft. just completed. Affiliation with medical school. Send inquiries to Box 858, c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510 Chicago, Illinois 60603.

GEN. SURGEON, CERTIFIED. Large multi-specialty group with active office and hospital practice. Salary $50,000 to $60,000 range, malpractice, retirement and all other benefits paid, teaching opportunities. Excellent schools, cultural activities and outdoor sports. Full vitae and references invited. Box 80100, St. Paul Minnesota 55108.

PSYCHIATRIST: Board Certified or eligible. Multidisciplinary Community Mental Health Department of nationally known Health Center —urban Chicago. Comprehensive child and adult mental health services, individual psychotherapy, active sustaining care program, available attending status with back-up teaching Hospital. Excellent fringe benefits, Salary commensurate with experience. Write or call Dr. Mollie E. Oroff, Chief of Psychiatric Services, Mile Square Health Center, Inc., 2045 West Washington Blvd., Chicago, Illinois 60612.

INTERNIST PREFERRED. Part-time Position: Regional medical officer Bureau of Disability Insurance Social Security Administration three or four 3 hour sessions per week—$76.00 per session serves as chief medical consultant to the regional representative in working with top medical advisors in a six state region. Submit curriculum vitate to: Bureau of Disabilty Insurance, 300 South Wacker Drive, 12th floor, Chicago, Illinois 60606. Attention: Analysis and evaluation section.

FAMILY PHYSICIAN needed by Group—3 FP's, GS & OB-Gyn. College town of 30,000. 155 bed modern hospital. Good salary, insurance and retirement benefits. Call or write: Charles G. White, M.D. (312) 355-2000, Wolf Medical Group, S.C., Naperville Plaza, Naperville, IL 60540

PSYCHIATRIC RESIDENCIES—APPROVED 3 YEAR university program: broad based program utilizing interdisciplinary approach in all treatment modalities with active academic involvement throughout; program offers training in general and psychiatric hospitals and community clinics; liaison psychiatry emphasized; research electives in clinical biofeedback, biological psychiatry, and clinical psychiatry; electives in crisis intervention, community psychiatry, alcoholism, addiction, consultation, child, adolescent and forensic psychiatry available; a balanced residency with intense supervision and flexibility to meet individual career goals; positions available at all 3 years. For full information write: E. L. Loschen, M.D., Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, Illinois 62708.

FOR SALE, LEASE OR RENT

FOR RENT 4010 W. MADISON ST., CHICAGO—OFFICE SPACE available for Medical Doctors. Physician short area; large number of people in need of additional physicians. 1-2-3 Room Suites. Immediate Possession. Call: Illinois Property Management Corp., Mr. R. M. Ryan, Agent. 312-VA 6-4438 or 379-1133.

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DOCTORS WHY PAY RENT: Buy an 800 sq. ft. Medical suite luxuriously finished and absolutely independent in a newly completed Medical Center in Barrington, Ill., a desirable place to start a practice and to live. Ample paved parking. Just a few blocks from the future Good Shephard Hospital. Excellent terms. Write Box 852, Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chgo., Ill. 60603.

ATTRACTIVE ALL ELECTRIC BUILDING WITH waterfall in lobby and two story skylight with balcony. Adjoins active shopping center —has direct access to Pharmacy. Medical Suite—800 sq. ft. fully carpeted, private office plus three exam. rooms each with counter, cabinet and sinks. Large waiting room. Receptionist area. $600.00 per month all utilities included. Other suites finished to suit—500 to 2500 sq. ft. Tag Realty & Dev., Inc., Schaumburg Plaza, 1443 W. Schaumburg Rd., Schaumburg, Ill. 60172; 529-0506.

THREE MEDICAL SUITES for individual and or group practice available at 5100 Lincoln in Lisle. Please call Sandi Hutchings at 969-5333.

THE LANGUAGE WE SPEAK IS: AAA tenants, deferred equity payments, existing mortgage, joint venture, land bank, multi-depreciation, net, net, net, leases, positive cash flow and tax shelters.

WE DEAL IN: apartment complexes, golf courses, farms, industrial building, resorts, shopping centers, strip stores & zoned land.

We have 468 apartment units in the Chicago suburbs priced from $16,000 to $20,000 per unit and up to 9% cash on cash return.

Our industrial and commercial properties average 10% cash flow, have a median age of 3 years and are available from $22,000 equity.

For further information please call Harrald at (312) 420-2777 or write; VISION REALTY, 1121 W. Ogden, Naperville, Illinois 60540.

RARE COINS—Gold, Silver, Type Coins Approved and Certified for Keogh, pension or private investment. Bullion fluctuates and is speculative, but select rare coins increase value consistently. Physician's hobby of many years converted to sound counseling service. Confidential, write for recommended plan. Box 854, c/o Illinois Medical Journal, 55 E. Monroe, Chicago, Illinois 60603.

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BIOFEEDBACK INSTRUMENTS—Bio-Dyne Corp. produces a complete line of clinical biofeedback instruments for treatment of—Tension and migraine headaches, muscle re-education, anxiety, hypertension, Raynaud's syndrome, stress control . . . For more information or a no obligation demonstration, please write or call BIO-DYNE CORP., 161 E. Erie St., Chicago, Ill. 60611. 312-649-0303.

CREDIT AND COLLECTION MANUAL recently made specifically for medical profession. Easy to use for excellent results. Satisfaction guaranteed or money refunded. $15.95. H. Spear, Hopkinson House 1717, Washington Square South, Philadelphia, Pa. 19106.

BLUE SHIELD REPORT FOR *Illinois Physicians*

Send Claims to Proper Blue Shield Plan

Illinois Blue Shield's Case Service Department forwards an average of several hundred claims each month to other Blue Shield Plans for services to out-of-state subscribers. Each Plan processes claims for its own members, and payment delays can be avoided by mailing Blue Shield Service Reports directly to the Plan involved. The address of the Plan is listed on the subscriber's indentification card.

Most of the claims we forward are for services to members enrolled in Plans bordering Illinois. For your convenience, the addresses of these Plans are listed below. A directory of Blue Shield Plans was published in the Medical Assistants' Handbook.

Blue Shield Plans bordering Illinois are:

Wisconsin:

Wisconsin Physicians Service
330 East Lakeside Street, PO Box 1109
Madison, Wisconsin 53202

Surgical Care, the Blue Shield Plan of the Medical Society of Milwaukee County
756 North Milwaukee Street
Milwaukee, Wisconsin 53202

Iowa:

Blue Shield of Iowa
Liberty Building
Des Moines, Iowa 50307

Indiana:

Blue Shield Plan of Indiana
120 W. Market Street
Indianapolis, Indiana 46204

Kentucky:

Kentucky Physicians Mutual, Inc.
3101 Bardstown Road
Louisville, Kentucky 40205

Missouri:

Blue Shield Plan of Kansas City
3637 Broadway, PO Box 169
Kansas City, Missouri 63042

St. Louis Blue Shield
5775 Campus Parkway
Hazelwood, Missouri 63042

Michigan:

Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226

Exceptions to the rule apply to members enrolled in the Reciprocity Program and National Accounts. Claims for services to these subscribers should be sent to Illinois Blue Shield, 233 North Michigan Avenue, Chicago, Illinois 60601.

Subscribers in the Reciprocity Program have identification cards with a double-pointed red arrow in the upper left corner, with a series of three number preceding the letter "N", i.e. "123N". The number indicates the Home Plan of the patient, but Illinois Blue Shield will process the claim. Always enter the N-number and the patient's group and certificate number on the Physician's Service Report form.

Members enrolled in National Accounts have identification cards with the wording "Central Certification" or "National Account" in an outline map of the U.S. in the upper right portion of the card. The name of the employer is also generally printed prominently on the face of the card. After the subscriber's name is a two or three letter Alpha Prefix and a three digit number, i.e. SHW-333, then the employee's Social Security Number. Enter these identification numbers on the Service Report form to avoid claim processing delays and send the Service Report to Illinois Blue Shield at the above address.

Blue Cross-Blue Shield Plans Merge

The Blue Cross and Blue Shield Plans of Illinois merged October 1, 1975.

The combined financial and human resources of the two corporations enables us to meet the increasing demand for more comprehensive health care coverage and to improve service to our members and their physicians.

The merger in no way changes the medical-surgical-hospital benefits covered under existing certificates. When new certificates are issued they will show "Health Care Service Corporation", our new official name. However, Blue Cross and Blue Shield will still appropriately identify the single Plan.

ASK BLUE SHIELD
. . . ABOUT MEDICARE

BEFORE YOU MOVE . . .
Give Carrier Adequate Notice

To prevent Medicare payments from going to an incorrect address, or to a billing service you discontinued because of relocating your practice or for other reasons, always give the Part B Medicare carrier (Blue Shield in Cook County) adequate notice —at least 3 weeks in advance of when these changes occur.

When discontinuing or changing to another billing service or agent, remember to rescind the power of attorney you vested in the agent or service you were using, and inform us of the fact in writing so that further Medicare payments are not sent to a non-authorized agent or facility.

Effective Date Important

Notification of your relocation to a new address should be sent to us by letter, giving us your present office address, your new address, provider identification number, city, state and zip code, *with the effective date of the address change.* If your new practice location is within our carrier jurisdiction for processing your Part B claims, new address labels will be sent to your new billing address.

If a new billing service or agent is involved, advise us by letter with your signature that you have authorized the service to submit claims and receive payments, and give us the agent or facility's complete name, address and telephone number.

Information involving change of address or new billing service should be sent to:

Provider Update File
Medicare B
P.O. Box 2218
Chicago, Illinois 60690

Documentation Of In-Hospital Visits

Physicians submitting claims for hospital visits to Medicare patients should document the visits with an entry in the hospital record for each patient, which indicates the date of the visit.

Payment may be denied if a review of the hospital records fails to show the necessary documentation of the visits. Without the information in the record, a physician could be asked to refund a payment at a later date. Documentation also provides proof of visits made if a beneficiary raises a question with the carrier on charges billed for visits.

A rule of the hospital that the physician is required to visit patients daily is not considered a sufficient basis for the carrier to pay the claim. Acceptable documentation would be a physician's progress notes indicating he visited the patient on certain days, or a patient's statement that the visits were made. Entries in the physician's own office records are not considered as substantive as the hospital record.

A physician should bill only for visits he made himself. Whether he uses the SSA-1490 Request for Medicare Payment form, or his own billing statement, he should indicate the number of days the patient was visited and the charge for each visit. If the charge for the initial visit exceeds that of subsequent visits, the difference in the amount must be shown on the SSA-1490 form or billing statement.

Payment For Consulting Services

Payment for consulting services is made by Medicare when such services are determined to be reasonable and necessary to assist the attending or referring physician in assessing the patient's total medical condition.

A consultation is a request from the attending or primary physician for the advice and counsel of an accredited specialist. For payment of services by Medicare, a consulting physician must—on either the SSA-1490 form or his own billing statement—state the diagnosis and give the name and address of the referring or attending physician. A consultation must include a history, examination and written report filed with the patient's permanent medical record maintained by the attending physician.

A referral is not considered a consultation. Referral implies the transfer of a patient to another physician for the management of a specific condition or procedure. In the case of a consultation, the patient most generally is returned to the primary physician. When it is decided that the patient would best be served by having the condition managed by the consulting physician, any continuous reimbursement to both physicians is evaluated on the special circumstances involved. The initial examination would be considered a consultation and is reimbursable if medically necessary and reasonable.

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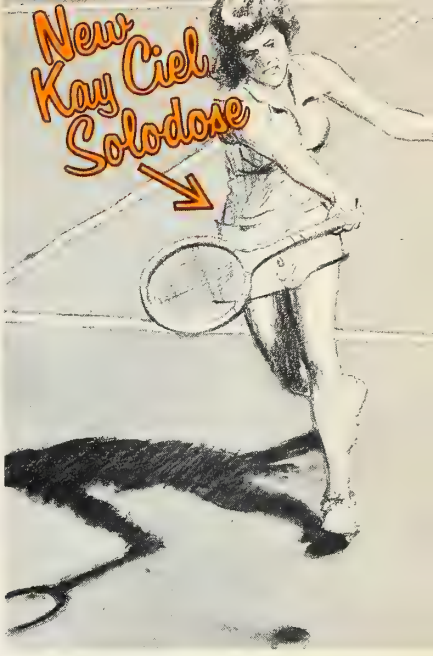
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The *Illinois Medical Journal* is published by the Illinois State Medical Society as an educational and professional informational magazine and distributed as a benefit of membership in the Illinois State Medical Society. Its intent is to keep members current in medical knowledge and is a part of a continuing medical education program. Socioeconomic matters, affecting as they do a changing pattern in the proper delivery of medical care, are considered an inherent element in medical education.

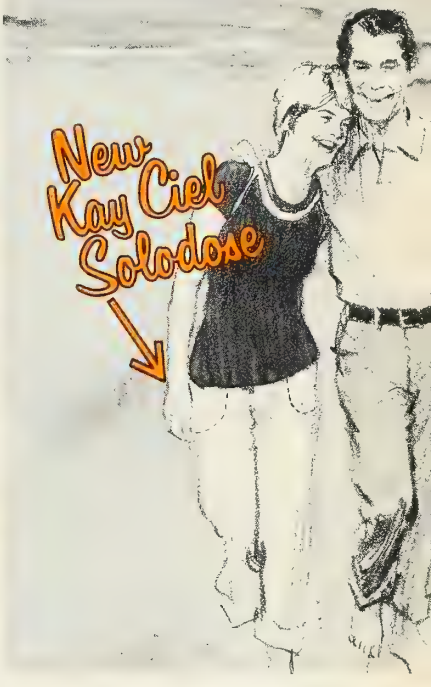


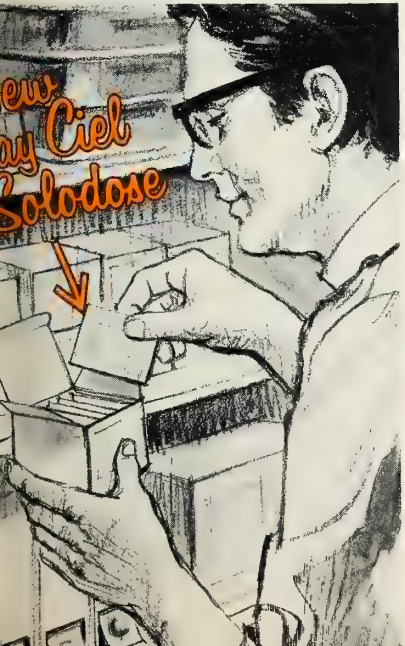












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Clinics for Crippled Children Listed for December

Twenty-six clinics for Illinois' physically handicapped children have been scheduled for December by the University of Illinois, Division of Services for Crippled Children. The Division will count eighteen general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical, social and nursing services. There will be six special clinics for children with cardiac conditions, and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

December 2 Carmi—Carmi Township Hospital
December 2 Belleville—St. Elizabeth's Hospital
December 3 Hinsdale—Hinsdale Sanitarium
December 4 Sterling—Sterling Community Hospital
December 4 Litchfield—St. Francis Hospital
December 4 Lake County Cardiac—Victory Memorial Hospital
December 8 Peoria Cardiac—St. Francis Children's Hospital
December 9 Peoria—St. Francis Children's Hospital
December 10 Rock Island Cerebral Palsy—Foundation for Crippled Children and Adults
December 10 Champaign-Urbana—McKinley Hospital
December 11 West Frankfort—Union Hospital
December 11 Springfield—St. John's Hospital
December 11 Kankakee—St. Mary's Hospital
December 12 Chicago Heights Cardiac—St. James Hospital
December 15 Peoria Cardiac—St. Francis Children's Hospital
December 16 East St. Louis—Christian Welfare Hospital
December 16 Peoria—St. Francis Children's Hospital
December 16 Rock Island—Moline Public Hospital
December 17 Springfield Pediatric-Neurology—Diocesan Center
December 17 Aurora—St. Joseph Mercy Hospital
December 17 Chicago Heights—St. James Hospital
December 18 Rockford—Rockford Memorial
December 18 Bloomington—Mennonite Hospital
December 18 Elmhurst Cardiac—Memorial Hospital of DuPage County
December 19 Evanston—St. Francis Hospital
December 19 Chicago Heights Cardiac—St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children. ◄

PROLOID® (thyroglobulin)
Caution: Federal law prohibits dispensing without prescription.
Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.
Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.
The ratio of T_4 and T_3 in Proloid (thyroglobulin) is approximately 2.5 to 1.
Proloid (thyroglobulin) is stable when stored at usual room temperature.
Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.
In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.
Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.
Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.
Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.
Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.
Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.
Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.
Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, $T_3{}^{131}I$ resin sponge uptake, $T_3{}^{131}I$ red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.
Instructions for Use. The following conversion table lists the approximate equivalents of other thyroid preparations to Proloid (thyroglobulin) when changing medication from desiccated thyroid, T_4 (sodium levothyroxine), T_3 (sodium liothyronine), or T_4/T_3 (liotrix).

CONVERSION TABLE

Dose of Proloid (thyroglobulin)	Dose of Desiccated Thyroid	Dose of T_4 (sodium levothyroxine)	Dose of T_3 (sodium liothyronine)	Dose of liotrix (T_4/T_3)
1 grain	1 grain	0.1 mg	25 mcg	#1 (60 mcg/15 mcg)
2 grains	2 grains	0.2 mg	50 mcg	#2 (120 mcg/30 mcg)
3 grains	3 grains	0.3 mg	75 mcg	#3 (180 mcg/45 mcg)
4 grains	4 grains	0.4 mg	100 mcg	
5 grains	5 grains	0.5 mg	125 mcg	

In changing from Thyroid USP to Proloid (thyroglobulin), substitute the equivalent dose of Proloid (thyroglobulin). Each patient may still require fine adjustment of dosage because the equivalents are only estimates.
Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.
(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)
Supplied. ¼ grain tablets in bottles of 100 (N0047-0250-51) and 1000 (N0047-0250-60); ½ grain tablets in bottles of 100 (N0047-0251-51) and 1000 (N0047-0251-60); scored 1 grain tablets in bottles of 100 (N0047-0252-51) and 1000 (N0047-0252-60); 1½ grain tablets in bottles of 100 (N0047-0253-51) and 1000 (N0047-0253-60); scored 2 grain tablets in bottles of 100 (N0047-0257-51); 3 grain tablets in bottles of 100 (N0047-0254-51) and 1000 (N0047-0254-60); scored 5 grain tablets in bottles of 100 (N0047-0255-51) and 1000 (N0047-0255-60). Full information is available on request. P-GP-51 4/c

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Editorials



Rural Health Care

Four-fifths of the people of disadvantaged countries live in rural areas on small plots of land and in extremely restricted social groups. Contrasts of climate and topography add to this dilemma—now drought-stricken, now flooded. Health care got short shrift because it never played a role in their way of life. So, the people sought solace in their religious beliefs, which adequately explained the basis for most of their troubles, including illness and death.

But during this century, many achievements have been made and these are adequately described in the book, "Health by the People" (edited by Kenneth W. Newell, World Health Organization, Geneva, 1975). This book tells of the dramatic changes in 10 rural groups. Emerging from rural hopelessness was not easy. But during the past 25 years, various plans, such as the extension of health services from the towns toward the villages, were initiated. One could describe this as an "outreach" program. Other government agencies approached the total situation by introducing a series of inter-related political, economic, and social measures. One must understand their achievements only by accepting their goals which ranged from that of health as a political and social right to that of health as an expression, or spinoff, of a properly-functioning and informed community.

In essence, they do not always base the success of their plan by infant mortality, prevalence of disease, or the number of immunizations given. Everyone understands that infants need food, pregnant women give birth to a child, and that immunizations are useful. Health care as we know it is intertwined with their political beliefs. They concentrate on resources that will enable the people to eat and be educated; community responsibility; self-sufficiency in all important matters; and a reliance on outside resources only for emergencies. They preach the uniqueness of each community coupled with individual group pride and the dignity associated with it. This is fine, yet it does little good in treating pneumonia, heart attacks, and malaise.

Unlike the Western type of medicine we know, the community comes first. It selects and trains a primary health care worker who is not a conventional doctor or nurse.

In general, health in these areas becomes a community responsibility. And, if rural and community development is to progress, the persons involved with health must also be able to change, improve, and adapt to keep up with community organization. This, in effect, is what health by the people is all about.

The examples presented in the book fall into three overlapping categories: national change (China, Cuba, Tanzania); extensions of existing systems (Iran, Nigeria, Venezuela); local community development (Guatemala, India, Indonesia).

The first example was a national political decision to enlarge health care facilities. The second was done because there were large populations under-served in respect to health. The third group not only changed in scale, but in objective. Health was not given the first priority.

No one can argue with trail blazers so long as they do not exploit the people. The problem remains, and no one, as yet, has offered the solution.

T. R. Van Dellen, M.D.
Editor

Editorial Notice

There has been a considerable increase in investigative efforts in the broad areas of immunopathology and oncology in recent years. This knowledge is not only of a purely academic nature, but also is significant in terms of present or potential application as an adjunct to therapy and to clinical management of patients. Much has appeared in the literature and the average member of the biomedical community may have become somewhat "bewildered" due to the increase of information.

In keeping with the *Journal's* efforts to provide the membership with the latest knowledge, the Publications Committee authorized a brief series of timely and concise articles in immunopathology and oncology. These will correlate basic and clinical investigations in a general, but meaningful, manner, with emphasis on existing or potential clinical application. The initiation of this series, entitled: "Seminars in Immunopathology and Oncology", under the contributing editorship of Richard J. Ablin, will be in January 1976.



Retarded Citizens Can Be Helped

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DARVOCET-N® 100
propoxyphene napsylate with acetaminophen

Indication: For the relief of mild to moderate pain, either alone or accompanied by fever.

Contraindications: Hypersensitivity to propoxyphene or to acetaminophen.

Warnings: *Drug Dependence*—Propoxyphene can produce drug dependence characterized by psychic dependence and, less frequently, physical dependence and tolerance. Propoxyphene will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to that of codeine although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine. *Usage in Ambulatory Patients*—Propoxyphene may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, such as driving a car or operating machinery. The patient should be cautioned accordingly. *Usage in Pregnancy*—Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, propoxyphene should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards. *Usage in Children*—Propoxyphene is not recommended for use in children, because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric age group.

Precautions: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The central-nervous-system depressant effect of propoxyphene may be additive with that of other C.N.S. depressants.

Adverse Reactions: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, lightheadedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses exceeding 800 mg. per day has caused toxic psychoses and convulsions.

[011375]

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Contraindication: Hypersensitivity to propoxyphene, aspirin, phenacetin, or caffeine.

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Precautions: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The central-nervous-system depressant effect of propoxyphene may be additive with that of other C.N.S. depressants. Phenacetin has been reported to damage the kidneys when taken in large amounts for a long time. Salicylates may enhance the effect of anticoagulants and inhibit the uricosuric effect of uricosuric agents.

Adverse Reactions: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, lightheadedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses exceeding 800 mg. per day has caused toxic psychoses and convulsions.

[011375]

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If your angina patient* isn't having 3 out of 4 better days than usual... try Cardilate®
(ERYTHRITYL TETRANITRATE)

*Please note: unstable angina patients may be refractory to all long-acting nitrates

INDICATIONS: For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset of action is somewhat slower than that of nitroglycerin.

PRECAUTIONS: As with other effective nitrates, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilatation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

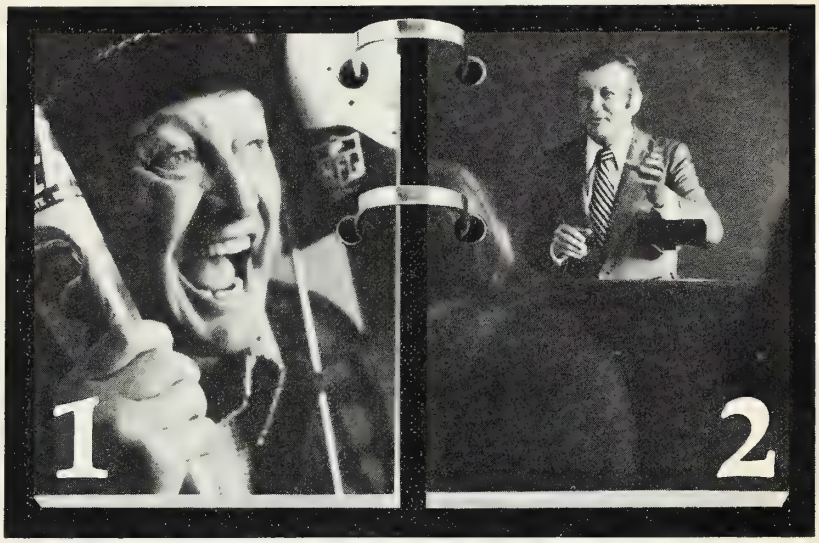
SIDE EFFECTS: No serious side effects have been reported. In sublingual therapy a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustment of the cerebral hemodynamics to the initial marked cerebral vasodilatation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

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SUPPLIED: 10 mg chewable tablets, bottle of 100. Also 5, 10 and 15 mg scored tablets in bottles of 100. 10 mg scored tablets also supplied in bottle of 1,000.

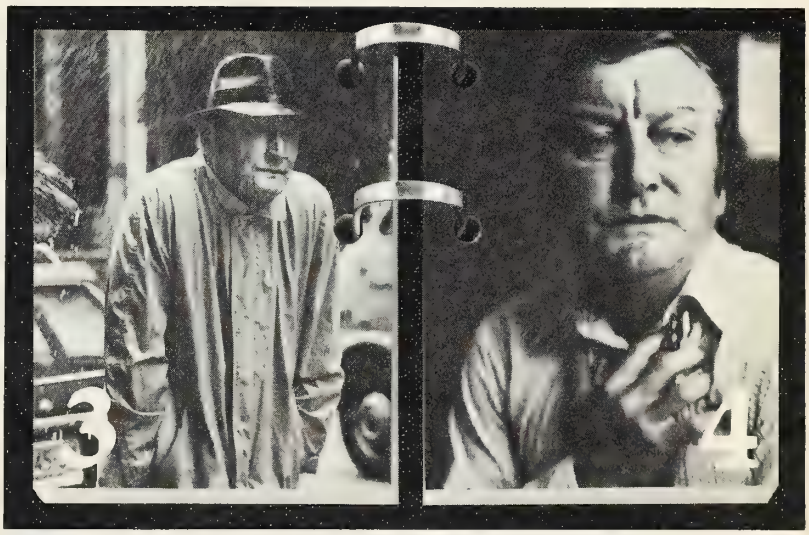
Also available: Cardilate® P brand Erythrityl Tetranitrate with Phenobarbital* (*Warning: may be habit-forming).

1. Russek HI: AM J M Sc 239:478, 1960



"Pain days" significantly reduced with Cardilate® (erythrityl tetranitrate) in 48-patient study.[1] Patients on placebo experienced same pain as usual or increased pain 2 days out of 3...compared to 1 day out of 4 while on Cardilate.

Rapid-acting chewable tablets (10mg) preferred by many patients. Should be given before anticipated periods of stress to produce an action within 5 minutes and lasting up to 2 hours. Sublingual tablets also available.

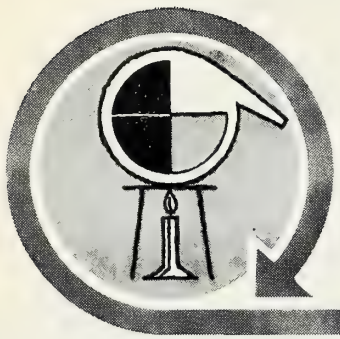


Effective prophylaxis against attacks; increases exercise tolerance. Serious side effects have not been reported in 20 years' clinical use.

Cardilate can save patients money; is less expensive than many popular long-acting nitrates. 20% to 30% savings not uncommon...also helps reduce need for nitroglycerin.

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new pharmaceutical specialties

By Paul Dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

New Single Drugs—Drugs not previously known, including new salts.

Duplicate Single Drugs—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

NEW SINGLE DRUGS

CLONOPIN — Anticonvulsant Rx

Manufacturer:	Roche Laboratories
Nonproprietary Name:	Clonazepam
Indications:	Used alone or as adjunct in Lennox-Gastaut syndrome (petit mal variant), akinetic and myoclonic seizures.
Contraindications:	History of sensitivity to benzodiazepins, liver disease and acute narrow angle glaumoca.
Precautions:	See package insert.
Dosage:	See package insert.
Supplied:	Tablets, 0.5; 1 and 2 mg

DTIC-Dome — Cancer Chemotherapy Rx

Manufacturer:	Dome Laboratories
Nonproprietary Name:	Dacarbazine
Indications:	Metastatic malignant melanoma. May be combined with other drugs used in cancer chemotherapy.
Warnings:	Hemopoietic depression most serious toxicity.
Precautions:	Used in hospitalized patients who can be carefully observed.
Dosage:	See package insert.
Supplied:	Vials, 100 and 200 mg.

TRIAZURE — Systemic Antipruritic Rx

Manufacturer:	Parke Davis
Nonproprietary Name:	Azaribine
Indications:	Symptomatic control of extensive, severe, recalcitrant psoriasis which has failed to respond to topical therapy. Diagnosis must be established.
Contraindications:	Pregnancy
Warnings & Precautions:	See package insert.
Dosage:	See package insert.
Supplied:	Tablets, 500 mg.

UTIBID — Urinary Antibacterial Rx

Manufacturer:	Warner-Chilcott
Nonproprietary Name:	Oxolinic Acid
Indications:	Nonobstructive urinary tract infections caused by susceptible organisms.
Contraindications:	Do not use in infants or nursing mothers.
Warnings:	May stimulate central nervous system, especially in the elderly.
Dosage:	1 Tablet twice daily for two weeks.
Supplied:	Tablets, 750 mg.

DUPLICATE SINGLE DRUGS

ERYTHROMYCIN STEARATE Lederle — Broad Spectrum Antibiotic Rx

Manufacturer:	Lederle Laboratories
Nonproprietary Name:	Erythromycin stearate
Indications:	Infections caused by streptococcus pyogenes in upper and lower respiratory tract, skin and soft tissue.
Precautions:	Impaired liver function. Therapeutic dose should be administered for ten days.
Dosage:	See package insert.
Supplied:	Film coated tablets, 250 mg (base).

GG-CEN Capsules — Cough Therapy o.t.c.

Manufacturer:	The Central Pharmacal Co.
Nonproprietary Name:	Glyceryl guaiacolate
Indications:	Temporary relief of dry nonproductive cough.
Dosage:	Adults, one capsule every four hours as needed.
Supplied:	Capsules, 200 mg.

GRIS-PEG — Systemic Fungicide Rx

Manufacturer:	Dorsey Laboratories
Nonproprietary Name:	Griseofulvin (ultramicrosize)
Indications:	Various forms of ringworm infections.
Contraindications:	Porphyria, hepatocellular failure.
Precautions:	Accurate diagnosis of the infecting organism is essential.
Dosage:	125 to 250 mg daily, depending on organism treated. Children; see package insert
Supplied:	Tablets, 125 mg.

HYPERSAL — Eye Preparation Rx

Manufacturer:	Softcon Products, Div. Warner-Lambert

(Continued on page 545)

American Association of Medical Assistants — Illinois Chapter

AAMA Convention '75

By Judith Miller, CMA-AC, *Public Relations Chairman*

Educational programs and certification raced to the wire in Derbytown, USA during the 19th Annual Convention of the American Association of Medical Assistants, Inc. "AAMA-Fast Track to Education" was the prevailing theme of the 1975 national convention, held in early October, in Louisville, Kentucky. Over nine hundred medical assistants, physicians and educators nationwide, attended. As ever-increasing demands for quality health care are being made upon each member of the health care team, an emphasis was placed on certification and continuing education for medical assistants. The educational sessions featured outstanding authorities from around the nation speaking on patient education, legislation and credentialing, and the latest advances in health care. Opening the first session was William H. Knisely, Ph.D., Assistant to the Chancellor for Health Affairs, University of Texas System, Austin. He spoke on the future of health care in the United States. Highlights of other sessions focused on legislation and credentialing, with moderator John J. Fauser, Ph.D., Assistant Director, Department of Allied Medical Professions and Services, American Medical Association, Chicago; federal health manpower leg-



Newly-elected AAMA Advisor, John L. Wright, M.D., of Bloomington, Illinois, chats with Illinois Society President, Magda Brown, Chicago.



AAMA President, Laura Lockhart, CMA-A, Akron, Ohio, listens as Illinois Society President, Magda Brown (left) issues an invitation for medical assistants nationwide to attend the 1976 AAMA annual convention in Chicago.



William Samuels, Executive Director, American Society of Allied Health Professions, Washington, D.C. (left) visits with Magda Brown, Illinois Society President; Alice Schneider, AAMA Staff; and J. Rhodes Haverty, M.D., Dean of School of Allied Health Sciences, Georgia State University, Atlanta.



Luella Mitchell, Chicago, AAMA Board of Trustees



June B. Hall, CMA-A, Danville, AAMA Speaker of the House

islation as it relates to the delivery of health care, by William Samuels, Executive Director, American Society of Allied Health Professions, Washington, D.C.; and trends in allied health education, by J. Rhodes Haverty, M.D., Dean of School of Allied Health Sciences, Georgia State University, Atlanta.

Hoyt Gardner, M.D., Louisville, member of AMA's Board of Trustees, conveyed official greetings at the Inaugural Banquet, at which time Laura L. Lockhart, CMA-A, Akron, Ohio, assumed the presidency for 1975-76. Illinoians who hold national AAMA offices include John L. Wright, M.D., Bloomington, AAMA Advisory Board; Luella Mitchell, Chicago, AAMA Board of Trustees; June B. Hall, CMA-A, Danville, AAMA Speaker of the House.

During the Awards Luncheon, Illinois Society President, Magda Brown, issued an invitation to attend the 1976 national Convention in Chicago, to be hosted by the Illinois Society. Joining in the invitation were Norma R. Domanic, New Lenox, General Convention Chairman, and Jean Berchinski, Dolton, Vice-Chairman. The convention will be held at the Palmer House, September 17-24, 1976.

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION
(Act of August 12, 1970: Section 3685. Title 39, United States Code)

1. Title of publication: IMJ Illinois Medical Journal

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7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given.) Illinois State Medical Society, 55 E. Monroe, Suite 3510, Chicago, Ill. 60603.

8. Known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages or other securities (If there are none, so state): None.

9. For Optional Completion by Publishers Mailing at the Regular Rates (Section 132.121, Postal Service Manual) 39 U. S. C. 3626 provides in pertinent part: "No person who would have been entitled to mail matter under former section 4359 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matter at such rates."

In accordance with the provisions of this statute, I hereby request permission to mail the publication named in Item 1 at the reduced postage rates presently authorized by 39 U. S. C. 3626.
(Signature and title of editor, publisher, business manager, or owner) Richard A. Ott (Managing Editor).

10. For completion by nonprofit organizations authorized to mail at special rates (Section 132.122, Postal Manual). The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes have not changed during preceding 12 months.

11. Extent and Nature of circulation.

	Average no. copies each issue during preceding 12 months	Actual number of copies of single issue published nearest to filing date
A. Total no. copies printed (Net press Run)	13,600	13,900
B. Paid circulation		
1. Sales through dealers and carriers, street vendors and counter sales	198	200
2. Mail subscriptions	12,375	12,724
C. Total paid circulation	12,573	12,924
D. Free distribution by mail, carrier or other means		
1. Samples, complimentary, and other free copies	755	734
2. Copies distributed to news agents, but not sold	None	None
E. Total distribution (Sum of C and D)	13,328	13,658
F. Office use, left-over, unaccounted, spoiled after printing	272	242
G. TOTAL (Sum of E & F—should equal net press run shown in A)	13,600	13,900

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Richard A. Ott, Managing Editor

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Alcohol-Related Problems in a General Hospital Emergency Room

By Mark A. Amdur, M.D./Chicago

As part of an on-going project to monitor emergency room psychiatric service at Wesley Pavilion of Northwestern Memorial Hospital all ER charts for the period February 1973-July 1973 were reviewed. The total number of ER visits was 9933. A previous survey[1] *at the same institution was done in 1972 but failed to completely tabulate all alcohol-related problems.*

This communication discusses all ER visits where alcohol seemed in some way involved in bringing the individual to the ER. Any chart in which it was noted that the patient "had been drinking," "smelled of alcohol," "states he is an alcoholic," or in some way implicated alcohol was tabulated as an alcohol-related ER visit.

Prevalence of Alcohol-Related Problems

The total number of alcohol-related ER visits for the six-month period was 136. This represents 1.4% of the total number of ER visits during the period. The 136 visits were made by 126 different individuals. Since this study was a retrospective chart review it suffers from two problems. The first is the poor legibility of ER charts that made the available data base for certain features as low as 119. The second is that it yields only the minimal estimate of prevalence of alcohol-related problems. This study misses those persons who came to the ER and neither identified themselves as alcoholic nor were perceived as such by the ER staff. Wechsler et al[2] administered breathalyzer tests to over 6000 ER patients and found 22% of the men and 11% of the women to have positive readings.

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Nature of Alcohol-Related Problems

1. Directly related to alcohol consumption. 20.6% (N=28) of the alcohol-related visits were for such immediate consequences of drinking as: delirium tremens, "intoxicated," "drunk," "alcoholism," "hangover," or "withdrawal."

2. Gastro-intestinal complications. 16.9% (N=23) of the visits were for such reasons as gastritis, pancreatitis, or cirrhosis in individuals noted to be alcoholic.

3. Neurological complications. 14.0% (N=19) of the visits were for neurological problems linked to alcohol such as: seizures, syncope, "blackouts," or tremor.

4. Traumatic complications. 7.4% (N=10) of the alcohol-related ER visits were for acute trauma associated with an intoxicated state.

5. 8.8% (N=12) were visits for miscellaneous medical or surgical problems by individuals noted to be actively alcoholic. 2.9% (N=4) of the visits were by persons noted to be intoxicated but who left the ER before the presenting prob-

lem could be ascertained.

6. Psychiatric problems and alcohol.

The remaining 29.4% (N=40) of the alcohol-related visits were persons seen by the ER psychiatric consultant. For most of these visits alcohol was noted in association with other psychiatric problems such as anxiety, depression, or suicide attempt.

A content analysis of the chief complaint, as recorded verbatim by the ER secretary, was made on those 40 visits. In 34 of the 40 visits where a psychiatrist was eventually summoned the individual had already labelled himself as in need of emotional support by using phrases such as "I'm nervous;" "I'm depressed;" "I want to see the psychiatrist;" "I have a drinking problem." In none of the 96 visits managed solely by a non-psychiatric physician was a psychological word or phrase recorded in the chief complaint. This finding tends to confirm an earlier observation[3] that persons must clearly state their need for psychological services. Patients should not depend on the diagnostic acumen of non-psychiatric ER physicians to detect less than blatant emotional distress.

Disposition of Alcohol-Related Problems

16.9% (N=23) of all alcohol-related visits were admitted to the hospital. The overall rate of admission from Wesley Pavilion's ER is approximately 15% of all visits.[4] Ten persons were admitted to the psychiatric unit and 13 persons were admitted to medical-surgical units.

8.1% (N=11) of all alcohol-related visits terminated by the individual leaving the ER against medical advice. Overall, approximately 1% of all ER visits at Wesley Pavilion's ER end in the patient leaving against medical advice.[4] This difference seemed particularly striking.

Demographic Features of Person with Alcohol-Related Problem in the ER

The chart below compares certain demographic features of the 126 persons who made the alcohol-related visits with two other populations of persons coming to Wesley Pavilion's ER. The other populations are a statistically valid random sample of all ER visits in June of 1972 and all ER psychiatric consultations from the first six months of 1972: (Fig. 1) ◄

	Random Sample of all ER Visits	ER Psychiatric Consultations	Alcohol-related Visits
Male	54%	45%	68%
Female	46%	55%	32%
Employed	81%	55%	58%
Unemployed	19%	45%	42%
Modal Age	Third decade	Third decade	Fifth decade
Marital Status:			
Married	41%	28%	33%
Single	43%	47%	33%
Separated or Divorced	12%	19%	31%
Widowed	4%	6%	3%

Figure 1. Distinguishing features of persons coming to the ER with alcohol-related problems are that they are predominantly males; they tend to have a higher rate of unemployment (therefore they are less likely to have health insurance); they are older; and they are more likely to be separated or divorced than even the psychiatric population.

References

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2. Amdur, M. A. and E. N. Tuder, "Observations on Psychiatric Consultation in Emergency Room Settings," *Psychosomatics,* 16:73-76, 1975.
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SHAKING THE MONETARY TREE

Oil-exporting nations are expected to accumulate approximately $60 billion in oil revenues by the end of this year, yet can usefully absorb only $10 billion in developing their countries.

"The U.S. share of this flow of funds is calculated to be 25% of the total," comments Charles H. Smith, Jr., chairman of the Board of Directors of the Chamber of Commerce of the United States.

"Without some major changes in the current situation, this kind of horrendous capital transfer threatens to destroy the already shaky world monetary system as well as create havoc in the nations of Europe, North America and Japan."

Analysis of Fatal Blunt Trauma Presenting at an Areawide Trauma Center

By Vernon H. Bartley, M.D., F.A.C.S., F.R.C.S. (C)/Elmhurst

Trauma—Critical Care Fellowship Project is the systematic study of blunt injuries to the chest and abdomen, suffered by critically injured persons in automobile accidents in the geographical area served by the areawide Trauma Center of Memorial Hospital of DuPage County, Elmhurst, Illinois. Included in the study will be predisposing factors leading to those accidents and autopsy findings with related injury patterns.

Methodology

Patients studied fell into two broad categories:
(1) Dead-on-arrival (D.O.A.);
(2) Death following admission (D.F.A.)—(see Table I).

TABLE I

Total Number of Patients in Study			35
D.O.A.	21	D.F.A.	14

Age Range: 3 years to 75 years; median age 35.5 years
Sex Ratio: Male: Female 2.5:1
In traffic accidents the distribution of drivers to passengers to pedistrians was 18 to 11 to 5.

The 21 patients dead-on-arrival were studied from the following aspects: (see Table II)
(1) Driver, passenger, pedestrian, or other
(2) Vehicle involved (eg. auto, motorcycle = MC, bicycle = Cyc.)
(3) Contributory causes (eg. drugs, alcohol, time of accident)
(4) Injuries sustained (eg. M.B.D. = massive brain damage)
(5) Cause of death
(6) Injuries sustained
(7) Place of accident (eg. TST = Tristate Tollway, EWT = East-West Tollway, I-90 = Interstate 90)

From Table II, it is apparent that half (10) of these critical injuries occurred on state tollways and almost half (8) occurred on busy state arterial roads. Table III also indicates that arterial state roads with high volume traffic are more likely to be the scene of critical accidents than local roadways.

From this data one might infer that the higher speed limit is the chief danger of the tollways and arterial roads, or that the straight roads breed overconfidence on the part of their users.

The fatal accidents generally occurred, however, after daylight, when traffic volume was lower and other factors such as tiredness and slower reflexes are to be expected, not to mention alcoholic beverages. Death in practically all the 21 D.O.A. cases was either instantaneous or within two to three minutes, so that even if expert instant medical help were to have been available, their fatal outcome would (because of the very magnitude of injuries sustained) be the same. In other words, the most efficient trauma system in the world *does* have its practical limitations, just as medicine generally has its limitations in salvaging patients with irreversible organ disease damage.

Of the 14 patients brought in alive to the emergency department, study was made with regard to the following: (see Table III)
(1) Number of deaths in the emergency department
(2) Period of survival following admission
(3) Driver, passenger, pedestrian, or other
(4) Vehicles involved
(5) Contributory causes
(6) Injuries sustained
(7) Treatment administered
(8) Cause of death and hospital location
(9) Place of accident

Commentary

Of 35 fatal accidents, 21 were D.O.A. and 14 survived to the emergency room, where 6 further deaths occurred, due either to massive brain dam-



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TABLE II

Name Age	Place	Driver, Passenger, Pedestrian	Vehicle	Contributory Causes	Significant Injuries Sustained	Cause of Death	Survival Time
J.B. 45	TST	Driver/ Pedestrian	Auto	Minor accident preceded fatal accident 12:35 P.M.	Massive brain damage; Avulsions of abdomen and thigh; Multiple rib fractures; Lacerations of left chest, compound fractures of femurs, left humerus, ulna, and radius	MBD Multiple injuries: Internal hemorrhage	Inst.
J.C. 17	TST	Passenger	Auto	6:24 A.M.	Flail chest, fractured ribs; Contused face and head	Traumatic asphyxia with brain injury	0-2 mins.
J.C. 20	TST	Driver	Auto	10:14 P.M. Struck guard rail	Massive brain damage; Multiple bone fractures; Laceration, left diaphragm, liver, spleen, pulmonary hemorrhage; Hemothorax, bilateral	MBD Multiple injuries Internal hemorrhage	Inst.
D.C. 27	TST	Passenger	Auto	10:14 P.M. Struck guard rail	Occipital laceration; Periorbital edema and hematoma; Contusions of chest and abdomen	MBD	Inst.
A.D. 11	Local	Driver Cycle	Cycle versus Auto	6:30 P.M.	Fracture of right temporal; Contrecoup, left temporal, occipital and cerebellum	MBD	Inst.
H.E. 60	Rt. 83	Driver	Auto	Myocardial infarct	Myocardial infarct; Contusion of forehead	Myocardial infarct	0-2 mins.
J.G. 46	EWT	Passenger	Auto	10:14 P.M. 2-car head-on	Depressed occipital fractures; Fractures, nose and maxilla	MBD	Inst.
E.G. 37	EWT	Driver	Auto	10:14 P.M. 2-car head-on	Multiple skull and rib fractures/rupture of heart; fracture, cervical; Laceration, lungs, liver; Traumatic amputation, right leg; Bilateral diaphragmatic ruptures; Laceration, spleen; Fracture, dorsal 10 vertebra	MBD	Inst.
S.H. 16	Rt. 12-45	Pedestrian	Pedestrian versus auto	6:58 A.M. Slipped on crossing— Alcoholic driver	Basal skull fracture	MBD	0-2 mins.
R.K. 21	Rt. 83	Driver	Auto	1:25 A.M. Struck abutment	Multiple fractures, frontal bone skull; Bilateral extremity fractures; Fractures, facial and maxilla	MBD	Inst.
S.K. 26	Rt. 83	Passenger	Auto	1:25 A.M.	Multiple fractures, maxilla and mandible/right upper ribs	Brain contusion; Aspiration of blood	0-2 mins.
S.L. 19	Rt. 64	Driver	Motor Cycle	2:00 A.M. Speed—lost control	Multiple external contusions; Lacerations to head	Brain contusion	0-1 min.
M.M. 16	22nd St.	Driver	Cycle	versus auto— alcoholic driver	Extensive fractures of occipital bone and base of skull	MBD	Inst.

Table II—Continued

Name Age	Place	Driver, Passenger, Pedestrian	Vehicle	Contributory Causes	Significant Injuries Sustained	Cause of Death	Survival Time
J.M. 19	I-90	Passenger	Auto	10:14 P.M. Alcohol 2-car crash	Extensive laceration of liver with hemoperitoneum; Frontal contusion	Brain contusion Liver hemorrhage	0-3 mins.
J.P. 56	Local	Driver	Auto	Carbon monoxide poisoning	Multiple bilateral rib fractures; Pulmonary edema; Subcapsular hematoma, right lobe, liver	Asphyxia from carbon monoxide poisoning; Brain edema (confusion)	2 days following auto accident
J.P. 56	Local	Pedestrian	versus truck	10:30 P.M.	Retroperitoneal hemorrhage; Bilateral hemothorax; Massive rupture, left diaphragm; Herniation of abdominal viscera into left chest; Atelectasis, left lung; Multiple rib and pelvic fractures; Dislocation of 1st lumbar vertebra with compression of spinal cord	Traumatic asphyxia and hemorrhage	0-2 mins.
J.S. 47	TST	Driver	Auto 8:00 A.M.	Acute myocardial infarct— old infarcts —coronary bypass grafts	Multiple fractures, mandible; Multiple left rib fractures; Minor multiple lacerations; Contusions; Cervical vertebral fracture	Acute myocardial infarct	0-2 mins.
D.S. 68	Rt. 56	Passenger	Auto	Sudden braking skidded into another vehicle	Multiple rib fractures; Rupture lacerations, roots of both lungs with bilateral hemothorax and right flail chest	Traumatic asphyxia and hemorrhage	0-2 mins.
C.T. 18	EWT	Driver	Auto	10:14 P.M. Alcohol 2-car crash	12-cm. neck laceration; Severe comminuted fracture of left mandible	Exsanguinating hemorrhage; Aspiration asphyxia	0-2 mins.
E.T. 52	Rt. 56	Driver	Auto	Glazed road surface	Laceration of liver; Basal skull fracture; Subarachnoid hemorrhage; Contusion, right lung	Brain damage; Liver hemorrhage	0-2 mins.
D.H. 47	EWT	Driver	Auto	Diabetic Wet surface	Traumatic rupture of heart with tamponade; Traumatic injury to lungs and liver	Exsanguinating hemorrhage	0-1 min.

age or exsanguinating hemorrhage or a combination thereof. The shortest survival of the 6 emergency room deaths was 14 minutes and the longest (ironically a suicide) was 2 hours and 30 minutes.

Eight critical cases were salvaged in the emergency room to proceed to other hospital locations and receive further investigations and treatment. Their survival times ranged from 3 hours and 8 minutes to 102 hours and 20 minutes. Six of these salvaged died in I.C.U., one in X-ray (following a cerebral arteriography procedure), and one in surgery (at laparotomy). Of the total 35 cases, the chief causes of death were as follows:

Massive brain damage—22
Exsanguinating hemorrhage—11
Preceding myocardial infarct—2

Summary

From the above, it would appear reasonable to advocate and deduce the following:

(1) Continuation and intensification of efforts to train emergency medical technicians or ambulance personnel in immediate airway maintenance techniques, including intubation.

(2) Intravenous therapy en route to the emergency department.

TABLE III

Name Age	Place	Driver, Passenger, Pedestrian	Vehicle	Contributory Causes	Significant Injuries	Treatment	Cause of Death	Hospital Location at Time of Death	Survival Period
P.C. 71	Rt. 64	Pas.	Auto	versus tree	Traumatic rupture of right diaphragm; flail sternum-right hemothorax and contusion, right atrium	Code Blue protocol on admission (intubation, IV therapy, etc.)	Exsanguinating hemorrhage, right thorax and abdomen	E.R.	59 mins.
E.P. 51	Rt. 38	Pas.	Auto		Flail chest; rupture or root, right lung, right hemothorax; Rutpure of liver with hemoperitoneum; Mesenteric root hemorrhage	Code Blue protocol on admission	Exsanguinating hemorrhage, thorax and abdomen	E.R.	65 mins.
W.W. 51	Rt. 64	Dr.	Auto	2:06 A.M. Alcohol	Admitted comatose, cyanotic, weak carotid pulse, no BP, right pupil larger than left	Code Blue protocol on admission	Brain damage	E.R.	14 mins.
M.M. 18	I-90	Pas.	Auto	6:00 A.M. Driver asleep	Bilateral pulmonary contusions; Bilateral hemothorax; Lacerated spleen with hemoperitoneum; Brain injury	Intubated; Arterial blood gases; Supportive therapy IV Mannitol 20%	Brain damage; Traumatic asphyxia and aspiration of blood; Exsanguinating hemorrhage (spleen)	E.R.	1 hr. & 40 mins.
G.S. 14	Rt. 64	Dr.	Cycle	versus truck Sideswipe	Multiple depressed skull fractures; Subdural hemorrhage; Brain contusions; Pulmonary vein tear with 150 cc. blood in pericardial sac	Code Blue Protocol on admission	Brain injury; Subdural hemorrhage; Pericardial tamponade	E.R.	2 hrs. & 11 mins.
R.W. 47	I-90	Ped.	—	versus auto History of epilepsy	Severe cerebral contusion; Basal skull fracture	Intensive supportive therapy	Brain damage	E.R.	2 hrs. & 30 mins.
G.A. 25	Local main	Dr.	Motor Cycle	Alcohol—cannabis 3:00 P.M.	Brain stem contusion	Bilateral craniotomy; Bilateral arteriography, cerebral: Intensive supportive therapy	Respiratory arrest; Brain stem destruction	I.C.U.	22 hrs. & 49 mins.
R.M. 3	Local	Ped.	—	4:45 P.M. versus truck	Depressed fracture, occipital and right basal; Ruptured liver with hemoperitoneum; Complete atelectasis of lungs	Cerebral arteriography via right brachial artery	Severe brain stem damage	X-Ray	3 hrs. & 8 mins.
J.F. 71	Local	Ped.	—	Dragged by auto	Severe lacerations, left leg; Posterior disolcation, right hip; Multiple fractures and contusions	Blood transfusions and supportive Rx; Suture of major lacerations and reduction of right hip	Trauma hemorrhage	I.C.U.	30 hrs. & 20 mins.

Table III—Continued

Name Age	Place	Driver, Passenger, Pedestrian	Vehicle	Contributory Causes	Significant Injuries	Treatment	Cause of Death	Hospital Location at Time of Death	Survival Period
S.K. 26	Local	Dr.	Auto	versus truck Improper lane speed 10:06 P.M.	Bilateral tension pneumothoraces; Cerebral contusion with coma; Bilateral femoral fractures; Multiple fractures	Bilateral thoracostomy tubes, tracheostomoy and respirator; Abdominal paracentesis and lavage; Serial blood gases	Brain death	I.C.U.	56 hrs. & 55 mins.
D.M. 11	Local	Pas.	Auto	—	Ruptured liver; Multiple rib fractures	Intense supportive Rx; Exploratory laparotomy	Exsanguinating liver hemorrhage; Lacerated inferior vena cava	Surgery	3 hrs. & 25 mins.
Y.M. 75	Rt. 83	Pas.	Auto	Wrong lane head-on	Multiple contusions and lacerations of forehead; Concussion; Neurogenic and hypovolemic shock	Supportive Rx, intubation, serial blood gases	Brain stem injury	I.C.U.	53 hrs. & 20 mins.
D.R. 22	Rt. 53	Dr.	Auto	—	Admitted comatose; Decerebrate; Pupils dilated; Fracture, left femur	Intubated, supportive therapy; Left femur splinted; Serial blood gases	Brain death	I.C.U.	102 hrs. & 20 mins.
R.S. 54	Local	Other	—	Fell off roof	Temporal skull fracture; Subdural and subarachnoid hematoma; Tear, right diaphragm; Subcapsular hematoma, spleen	Craniotomy; Tracheostomy; Supportive therapy; Serial blood gases	Brain injury	I.C.U.	70 hrs.

(3) Placing of critical patients in the emergency room on portable oxygenator pumps, making further procedures and transfers easier and less hazardous to the injured patient, and allowing increased evaluation of coexistent critical injuries.

(4) Make the use of seat belts compulsory to reduce the high volume of head and thoraco-abdominal injuries in traffic accidents.

(5) Consider the use of protective headgear not only for motorcyclists but also more generally for auto drivers and their passengers. From this series alone the number of passenger and pedestrian fatalities together equalled the number of driver fatalities.

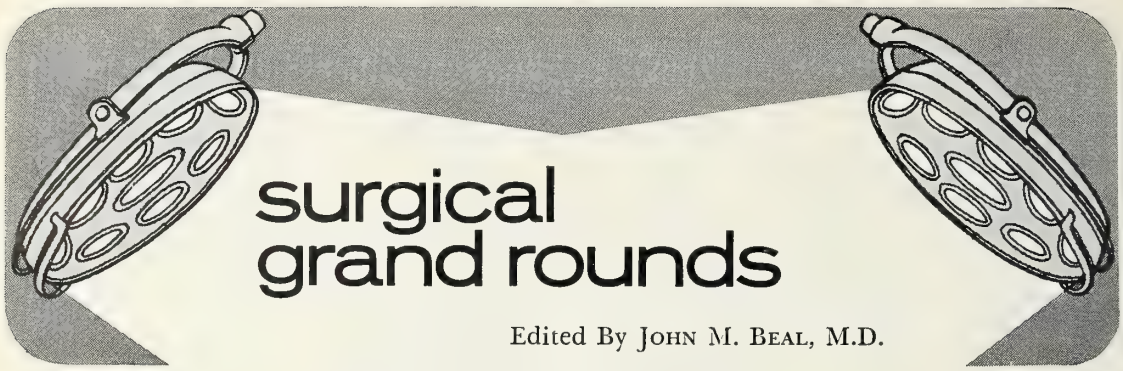
(6) The institution of life-saving procedures is greatly enhanced by an aware medical team. These procedures are facilitated by having an organized "Trauma Room" adjacent or in the emergency room with overhead X-rays available, and the gamut of necessary first-line equipment at hand.

(7) To conclude, the multiple trauma patient is in peril from his injuries from the moment of impact. If he has any chance at all, it will be due first to the degree of *non-injury* sustained by his vital systems (central nervous, respiratory, and cardiovascular), and secondly, if there is compromise of his vital systems, the speed with which support to these vital systems in the way of respiratory and blood volume replacement is given.

To accomplish this, the diagnostic and therapeutic tools and skills must necessarily be available. ◄

Acknowledgement

Grateful acknowledgement is made for their cooperation in this study to DuPage County Coroner, Robert K. ("Tiny") Matthews and to the pathologists at Memorial Hospital of DuPage County, Elmhurst, Illinois, Drs. Hugh Swartout, Don Johnson, and Hans Dolz.



Edited By John M. Beal, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of January 28, 1975.

Ruptured Abdominal Aortic Aneurysm

Dr. Emanuel Calenoff: A 73-year-old white male was found to have an asymptomatic five-centimeter diameter abdominal aortic aneursysm during routine physical examination at the time of admission for venous thrombosis and pulmonary embolism in August 1974. Because of the small size of the aneurysm and recent pulmonary embolism, operation was not advised at that time. He remained asymptomatic until two days prior to the present admission. He developed low back pain on the night of December 20, 1974 and was examined in the emergency room of a hospital. X-rays of his spine and abdomen were obtained and he was released with a diagnosis of lumbosacral back pain. He then experienced an increase in his low back pain, associated with crampy abdominal pain during the next 36 hours. While in transit to Passavant on December 22, he developed respiratory arrest but was resuscitated at a nearby hospital. He was then transferred to Passavant Pavilion Emergency Room (Northwestern Memorial Hospital) .

Physical examination revealed an apprehensive, hypotensive, 73-year-old white man with obvious poor peripheral perfusion. Abdominal examination revealed a 5½ centimeter diameter pulsating expansile abdominal mass without significant tenderness or other masses. Bowel sounds were hypoactive. He had intact femoral pulses bilaterally, but pulses were not felt distal to this level on either side. A left pneumothorax from an intracardiac epinephrine administration at the other hospital was detected and was treated with an apical chest tube. Whole blood transfusion was begun and he was taken immediately to the operating room.

Laparotomy was undertaken and a ruptured 6 centimeter diameter aortic aneurysm found. The aneurysm began just below the renal arteries and extended to the aortic bifurcation. Bilateral iliac and femoral artery aneurysms were also present. To manage this extensive aneurysmal involvement, a bifurcation graft was used with end-to-end femoral anastomoses. Vena caval ligation was also accomplished to prevent further pulmonary emboli during the postoperative period.

The postoperative management included maintainance of assisted ventilation for 24 hours. The chest tube was removed 48 hours after operation. A modest fascial dehiscence was noted on the seventh postoperative day. This was managed conservatively with abdominal support. The patient then improved, oral feedings were instituted, and he was discharged on the 18th postoperative day.

Dr. Leonid Calenoff: The chest films demonstrate a marked dilatation and elongation of the thoracic aorta. The films of the lumbar spine and the abdomen which were obtained for the back pain show an aneurysm of the abdominal aorta outlined by calcium (Fig. 1, 2). There are also degenerative changes of the lumbosacral

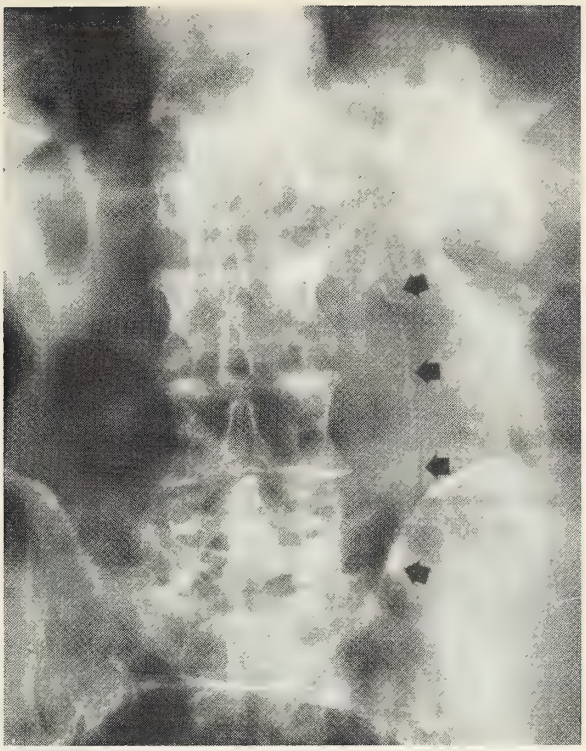


Figure 1. The arrows outline the calcific portions of the aortic aneurysm.

spine at L5 and S1, which can be seen better on the lateral view.

Dr. Richard Dean: Historically, a division between false and true aneurysms was suggested in the first century by Antyllus. Astley Cooper introduced the concept of ligation when he ligated an iliac aneurysm in 1817. Most of these patients died, however, from erosion of the ligature, secondary to infection. During the next 135 years, many treatments were employed including wrapping of the aneurysm and electro-coagulation with internal wiring to promote thrombosis. Dubost is given the credit for being the first to successfully resect an aortic aneurysm. Ormand Julian also accomplished this at about the same time here in Chicago. Since then the concept of graft replacement has become well established and widely employed.

The incidence of aneurysms varies with the population studied. Schaty studied 1400 asymptomatic people and found aneurysms in almost five percent of those over the age of 50. Although multiple causes have been suggested, aortic aneurysms probably result from degeneration of the wall from occlusion of the vasa vasorum which are the first branches of the lumbar arteries. In support of this is the fact that the lower lumbar arteries are usually found occluded at the time of operation.

More than 90 percent arise below the level of the renal arteries and are occasionally associated with iliac and femoral aneurysms as in our case. The diagnosis is usually made by careful physical examination. Eighty-five percent will be found if this is the only diagnostic tool employed.

Since most have calcifications in the aneurysm wall, A-P and lateral abdominal films are helpful and will show the aneurysm in from 55 to 85 percent. Recently, the introduction of isotope aortography and ultrasound scanning have further added to the accuracy of diagnosis so that virtually all are demonstrated if these tests are combined. On the other hand, contrast aortography is often misleading because of the extensive intraluminal clot and is only indicated in hypertensive patients, in unusually high aneurysms, or if distal occlusive disease is present.

Most patients with abdominal aortic aneurysms are asymptomatic when first seen. Occasionally, the patient may complain of chronic low back pain. Acute pain, however, is an ominous symptom. As this case demonstrated, the acute onset of back pain should alert the physi-



Figure 2. The lateral film of the lumbar region demonstrates the aneurysm.

cian to the probable imminent rupture of the aneurysm.

The natural history of this disease is grave. Virtually all will be dead within five years if left untreated and almost one-half will die from rupture.

In this regard, the size of the aneurysm plays a role. In a group of untreated aneurysms, Foster showed that 51 percent of those greater than 6 centimeters will rupture, while only 16 percent of those smaller than 6 centimeters will rupture during the follow-up period. This is important since many patients have multiple other risk factors, including heart disease, cerebrovascular disease, renal disease and senility. In such a high risk patient, conservative management of a small aneurysm is probably justified. Therefore, when making the decision for elective operation, both the size of the aneursym and the presence of undelying diseases play a role in the final decision. On the other hand, ruptured aneurysms are uniformly fatal if operations are not employed.

The site of rupture is usually in the left posterior lateral position as shown here. However, free intraperitoneal rupture or extension of the retroperitoneal hematoma into the peritoneal space may also occur.

Once the diagnosis is made, the patient should immediately be taken to the operating room. Resuscitation and operation should be undertaken as a continuum. If one plans to first resuscitate the patient and then move to the operating room, the patient will often have a repeat episode of cardiovascular collapse.

Intraoperative considerations for ruptured aneurysms include immediate control of the aorta above the level of the aneurysm. An aortic compression may be used for this if necessary. Proximal and distal control are then obtained. The aneurysm is then opened and the graft placed. As was stated, femoral aneurysms necessitated the placement of end-to-end anastomoses in our case.

The operative mortality of ruptured aneurysms is high and has ranged from 32 to 85 percent among the several reported series. If this is compared to the 100 percent mortality of untreated ruptured aneurysms, the justification for operation is obvious.

Finally to summarize this case, this 73-year-old white male had small aneurysms discovered during treatment for pulmonary embolism. Conservative management was correctly undertaken at that time. However, he then developed low back pain four months later. As his subsequent course demonstrated, this symptom should suggest the imminent rupture of the aneurysm and emergency repair should be immediately undertaken.

Dr. John Bergan: Aortic aneurysms occur in elderly males. Less than 15 percent of patients with aortic aneurysms are women. So it should be remembered that an elderly male presenting himself in the emergency room with back pain may indeed have pain of spinal origin, but his worst possible diagnosis is that of a rupturing abdominal aneurysm, and this fact should be remembered by every physician evaluating patients in the emergency room. The lateral film of the lumbosacral spine will usually show the curvilinear calcification of an aortic aneurysm. This can be diagnosed on abdominal palpation, but when one's attention is directed to the back, it is possible to forget to plapate the abdomen. On the other hand, a view of the lateral film of the abdomen should remind each of us to ask the patient to lie down and let us feel his abdomen to detect the expansile pulsations which are diagnostic of the aneurysm.

When such a patient is seen with an expanding or rupturing abdominal aneurysm, the nearest physician should notify the vascular surgeon and the patient should be moved to the operating room. The place to work up such a patient with a rupturing aneurysm is in the operating room. In patients such as the one being presented today, we are fortunate that the time from the onset of his symptomatology until he found himself in the operating room was as long as 48 hours. This is an example of the prolonged "golden interval", but we as physicians are unsure whether the interval in a given patient will last 30 seconds or 30 days. Most commonly, it is relatively short.

In the surgical suite, preparations for the major surgical onslaught should be made with haste. Large intravenous catheters should be placed, as well as a bladder catheter. Blood is sent to the laboratory for typing and cross-matching and baseline laboratory testing. The patient's abdomen is prepped and draped and no anesthesia is given until the surgical team has assembled and instruments are available for the operation. The surgical team must be ready to start the operation immediately upon the induction of anesthesia.

While today's has been a most interesting presentation, it really would not have been possible for us to discuss this subject if it had not been for Dr. Stan Carson's fast footwork in getting this patient out of the intensive care observation room and into the surgical operating room. ◄

The Psychological Reactions of Children to Burn Traumata: a Review

By Peter W. Breslin/Chicago

In the United States, 612,000 children are burn-injured annually.[1] *According to Berman et al., burns are the leading accidental killer of 1-4 year olds in the home; 37% of all deaths from burns each year are children under the age of 15 years.*[2] *These number about 2,000.*[3] *Savage and Leitch reported a general incidence rate in Australia of 1:3500.*[4]

Table 1 shows the distribution of burned children by sex, as reported in a number of well-carried out studies. It is interesting to note that the second and sixth studies listed had the highest "N's" and reported exactly equal percentages for sex distribution.

Table 1. Distribution of burned children by sex, according to selected studies.

Investigators	Boys %	Girls %	N =	Age Range
Long & Cope (5)	84	16	19	9 mos.-17 yrs.
Caudle & Potter (6)	56	44	119	
Holter & Friedman (7)	77	23	13	2 yrs.-10 yrs.
Vigliano, *et al.* (8)	70	30	10	
Galdston (9)	68	32	100	10 mos.-16.5 yrs.
Nelson & Palletta (10)	56	44	460	
Randolph, *et al.* (3)	61	37		

Long & Cope found seven of 19 children under four years old, two in the range 4-6 years old, four in the range 6-11 years old, and six in the range 11-17 years old. Fully two-thirds of Lunt's child victims were under two years of age.[11] Caudle & Potter reported 60% of their subjects to be under three years old, the mean age being 3.8 years, while the Vigliano et al. subjects averaged an age of 12.5 years. Galdston found 67% of his study children to be under the age of five. Forty-nine percent of Nelson & Palletta's subjects were under three years of age, 13% of them being less than one year old. Randolph et al. found that 54% of their cases were under three years old. Thus, it can be seen that children under the age of three years are somewhat over-represented among child burn victims.

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Types of Burn Injuries

In general, there are two kinds of burn injuries: those caused by contacting a hot liquid or other objects, and those caused by contact with an open flame. These two types of burns occur in different proportions with different age groups. Table 2 shows the relationships. It is obvious that the younger the child victims are, the more likely that the injury was caused by scalding. Seventy percent of Savage & Leitch's 1-3 year olds were scalded; 60% of Randolph et al's. study children were injured likewise, and there was a slight preponderance of males in this range. Furthermore, 85% of these incidents took place while at least one parent was present, though 81% were directly caused by the child himself. Sixty percent occurred in the kitchen, 20% in the bathroom.

Table 2. Peak ages for burn type, according to selected studies.

	Peak Ages	
Investigators	Flame Injuries	Contact Injuries (scalds)
Savage & Leitch	over 3 yrs. old	1-3 yrs. old
Nelson & Palletta	3-7 yrs. old	under 3 yrs. old
Randolph, *et al.*	5-6 yrs. old	18 mos.-3-yrs. old

In contrast, flame-burned children represented the minority of cases. There were more boys than girls in this group also. Far fewer of these incidents took place in situations with adults present, and the majority occurred out of doors, with the child's clothing typically igniting, causing severe, deep, and extensive burn injuries. Nelson & Palletta also reported the majority of all cases to be of the less severe contact variety. Twenty percent of all cases suffered permanent damage in the form of scarring as a result of their injuries, and the vast majority of these were of the flame type.

Smith[12] reported a mortality rate for child victims of 3%, as compared to an estimate of 2-5%

by Savage & Leitch for Australia. Interestingly, Randolph et al. reported that, while flame burns accounted for only 20% of all cases, they caused 80% of all deaths due to burns. Scalds accounted for 48% of all burn injuries, but only 20% of the mortality rate. Thus, it is quite clear that flame-type burns are usually far more severe, although they tend to occur less frequently than contact burns.

Child's Socio-Economic Group

Woodward[13] noted that burned children were statistically over-represented among: a) large families and b) poor families. Martin[14] and Smith concur especially with the latter point. Savage & Leitch also found a disproportionate number of families of burned children to have a low income; the fathers were typically employed in semi-skilled or unskilled manual labor jobs. Nelson & Palletta found black children to be proportionately under-represented (10% of all cases seen were black), while Vigliano et al. found 70% of their study population were white. They failed to indicate how many of the remaining 30% were blacks.

Responsibility for Burn

Concerning complicity in or responsibility for the fire or scald incident, Galdston reported that 76% of his subjects directly caused their own injury, 14% were burned by adults, and 10% by other children. Smith reported that 124 of his 168 patients (74%) directed the action that caused their own injury. Child abuse must be suspected in some cases. Holter & Friedman recognized three of their 13 study cases (23%) as being attributable to abuse (the children being between the ages of two and two and one-half years old)); however, Nelson & Palletta could verify abuse in only one case studied (0.2%). Obviously, a selection bias must be operative to account for such a gross discrepancy.

Burn Occurrences

Bezzeg[15] has delineated four types of burn occurrences:

1—accidental, due to caretaker neglect
2—victim-incurred
3—child abuse
4—purely accidental (not the fault of anyone)

Type three is rare (concurred with by Nelson & Palletta, disputed by Holter & Friedman). There may be important psychodynamic implications connected with the first two types of incident. For example, for type 1, while the parent or other custodial guardian did not directly cause the child to sustain the burn injury, he typically was present, and perhaps unconsciously was lax in vigilance and, thus, failed to anticipate the danger of the situation which caused the injury to the victim. The type 2 child may have a significant self-destructive aspect in his character.

Holter & Friedman classified their 13 cases, etiologically, into three categories: accidental (N = 3, 23%), situational crisis (N = 7, 54%), and child abuse (N = 3, 23%). Victims in the first category are psychosocially healthy prior to the incident, as are their families. Typical reactions of these victims are feelings of lonliness, hopelessness, isolation, estrangement, and helplessness. The psychological prognosis is usually good. Those who are victims of so-called situational crises are usually premorbidly disturbed in some way, as are the interactional and communications styles of their families. Those disturbances have led, indirectly, to the injurious incident. With psychiatric help, the prognosis for these children is encouraging. Child abuse is a rather well described clinical phenomenon; immediate psychiatric intervention is always warranted, and the prognosis is variable.

It is fairly well agreed that many injuries stem from the parental (maternal) neglect paradigmatic situation.[9,11] In these cases, Galdston relates, the child's innate curiosity is not adequately monitored by a parent. The mother's presence is usually an inhibitor of a child's otherwise dangerous knack for investigation of his world. Anything that the parent deigns as "not to be touched" is the first thing that the child, when he is alone, wants to examine. If this is an electrical outlet or some other potentially thermally harmful object, the risk to the child is great. Obviously, the solution is not for parents to decline to advise their children of the potentially hazardous nature of these things, but to monitor and regulate accordingly the child's natural inquisitive behavior until he is able to internalize the threat of danger, or is old enough to comprehend the existing danger factors.

Four Stages of the Hospitalized Child

Bernstein[16] has been able to identify four stages or phases through which the hospitalized child, of which the burn victim is a particularly good example, passes:

1—immediate (emergency) care phase
2—post-admission phase
3—middle phase
4—late phase

During the first phase, the child is usually in or near a state of shock. During the second, typical reactions of the victim include hallucination, extreme anxiety, and disorientation. The third, and longest phase may be characterized by a number of reactions. Depending upon his condition, the nature of the treatment he is receiving, and other things, the child may become extremely or moderately depressed, or, if skin grafting is planned, may gain hope and psychologically improve.[9] By this time, the psychiatrist should know the child and his family well and be able to interact meaningfully and in a therapeutic manner.

The last phase is characterized by the preparation for return to normal life. This can understandably be perhaps the most traumatic phase, psychologically, for the child. In a very real sense, his life and future have been significantly altered by the burn incident. The psychiatrist, with the help of the psychiatric social worker, must be able to help the victim to redirect himself in order to maximize his potential, drawing upon his remaining strengths to lead a happy and productive life.

Psychiatric Disturbances of the Child

When we speak of the child's psychological reaction to a burn injury, we are talking mainly about negative aspects. In addition, we must also consider somatic changes, since it is quite possible that many of the important changes that take place can be traced to organic origins. For instance, Long & Cope suggest that the behavioral problems in the burn victim might be engendered by physiological changes induced by the burn injury, such as metabolic and hormonal shifts, electrolyte loss, fever, etc.

Seligman[17] believes that the psychiatric disturbances of children must be assessed as stemming from three sources: the child himself, the injury, and/or the environment (primarily, parents and care agents, such as nurses). Specifically, Kjaer notes four sources of contribution to psychiatric disturbance: a history of psychological instability, psychic trauma attendant to the accident in which the burn injury was incurred, subsequent bodily deformation (scarring, an altered body image, and a blurred self/nonself boundary), and sensory deprivation due to the nature of some treatment regimens.

Prominent among the organic considerations are cerebral edema and renal complication, caused by the stimulation of epinephrine production, a reaction to the extreme stress of the situation, septiciemia, fever, and dehydration. These are often collectively labelled organic brain syndrome by clinicians. The signs in the patient's behavior include delirium, impulsiveness, confusion, irritability, poor memory, emotional lability, hallucination, and delusion, as well as reduced frustration tolerance capacity, accompanied by disorganized thinking, depression of initiative, and altered arousal patterns.

The chief psychological defense reaction syndrome he mentions begins with denial, possibly necessitating hallucination and delusion, then to repression, constriction and supression, and finally, hopefully, to acceptance. This sequence is the most typical course of psychological reaction of burned children in the emergency room.[18]

Anxiety

Anxiety, though, is perhaps the most intensely felt mental sensation of the child burn victim. Kjaer notes that fear is a major component for every burn victim, especially children. There are a goodly number of reasons for the child to be highly anxious and fearful. Woodward & Jackson[19] trace their roots back to three essential sources: the injury, the trauma of separation from mother, and the child's feeling that he is unloved, or bad and unworthy of love. He feels that if his parents loved him, they would not have let such a terrible thing happen to him.

As for separation anxiety, Martin believes that the younger child interprets the situation not as separation but as total and permanent loss of mother, understandably a source of very intense anxiety. This fear is especially aggravated and acute when the mother fails to visit often, or, due to treatment program, is unable to visit during the initial critical hours or days of hospitalization. Often, anxiety may be masked by a sheath of defensive aloofness; such children are typically reluctant to reconsider the burn-incurring incident.[8]

Long & Cope believe that the burn patient feels anxious mainly because his physical situation renders him totally helpless and dependent upon others for everything from eating to elimination. He may be ultimately as dependent as a newborn. Thus, it may be the adolescent or preadolescent who is the hardest hit, psychologically, by hospitalization for burns because they are at a time, developmentally, when they need to begin the process of exercising physical separation from the family. Thus, this patient may view the nurse symbolically as his mother, upon whom he is now totally dependent for the very essentials of life.[15]

Aggression may be a reaction to the frustration of helplessness.[18] Indeed, aggression is an oft-

encountered problem with child burn victims. Martin sees aggression as a protest against mother for allowing the injury to have happened, as well as for "abandoning" him (hospitalization). Usually, anger and aggression are directed against hospital staff, primarily nurses. Again, the possibility of the symbolic substitution of the nurse for the mother may account for this.

Loomis[20] and Long & Cope see aggressive or assaultive outbreaks as a reaction to the severe tension and often excrutiating pain experienced by these patients. The children often blame care agents for the infliction of pain, such as during the difficult process of debridement. Besides hostility, pain, and discomfort, Loomis notes feelings of guilt and negligence for the accident, interpretation of the suffering as a punishment—the child reasons that he must be, for some reason, deserving of such punishment—the anxiety of separation from the family, and feelings of inadequacy due to the state of helplessness, dependency, and loss of body integrity as the main reactions of children to burns.

Categorization of the Child's Reaction

Long & Cope have organized reactions into four categories:

1—anxiety due to an ignorant misunderstanding of a therapeutic procedure
2—regression/depression syndrome
3—aggression
4—guilt

Type 1, observable more often and to a more profound degree in the youngest children, may include a cause for aggression, or, because the hospital staff as well as parents are seen by the child as punishers, he may isolate himself from them and reject them, as he feels they have rejected him. Then the child may withdraw and regress. This process can be largely assuaged if time is taken to simply help the child to understand what is being done to him and why. The pain of dressings changings cannot be altered, but at least if the child realizes that nurses are not willfully inflicting pain but trying to help his injuries to heal, he may be less anxious and more co-operative.

Regression and depression, usually occurring unitarily, stem from feelings of abandonment by parents if they do not visit regularly and often, and of worthlessness and uselessness. Kjaer emphasizes that they usually stem from the inability of the patient to help himself with the basics of functioning. He recommends that the patient be allowed to do as much for himself as he is able.

Withdrawal often accompanies regression. Loomis sees this as a reaction to the overwhelming influx of noxious stimulation, not the least among them being the intense pain. Thus, in opposition to Kjaer, Loomis advocates getting the child to become very dependent upon care agents in order to prevent regression and withdrawal. Galdston believes that the regression in speech, thought, and motoric behavior in these patients is of two types: regression in order to conserve energy, and regression "in search of a relationship ". That is adaptive and maladaptive regression.

Long & Cope's fourth type, guilt, is traced to the feeling by the patient that his suffering is punishment for being a bad child. This patient suffers in silence, accepting it as deserved. Interestingly, he usually has a history of accidental injuries, suggesting a character disorder of the self-destructive variety.

Consequences of Isolation

As mentioned earlier, due to current treatment procedures aimed at minimizing the risk of infection of highly vulnerable burned tissue, child burn victims are often isolated from human contact as much as possible for periods of time. One undesirable consequence of this is that the child receives less than the optimal amount of sensory input. As is usually the case with sensory-deprived individuals, these children may experience hallucinations and delusions. The patient may talk to himself and reassure himself of his basic worth, or may express feelings of guilt and self-deprecation, interpreting that he is being punished for his wrong-doing by not having any visitors.[18]

Needless to say, this situation can and should be remedied if it occurs. A television set or radio, visitors through glass partitions who can communicate via an intercom, and many other methods can be used in order to keep the child in contact with reality while at the same time keeping him in an anti-septic environment.

Mental Reactions

Organic ramifications of burn injuries can cause extensive, diffuse mental reactions. In 1965, Petersen et al. reported findings that EEG activity was altered among severely burned patients. They noted right hemispheric diffuse dysrhythmia, bi-lateral slow wave bursts with some frontal-temporal focal slow waves, and reduced alpha activity in patients with deep burns. Asymmetrical but non-specific pathological EEG changes were associated exteriorly with auditory hallucinations, restlessness, and confusion. They

pointed out that, especially with children, neurological disorder and adverse psychological concommitants may be permanent.[21]

Pain, too, is an organic phenomenon, and we have already made reference to the fact that many of the psychological reactions of burn victims are in response to the intense pain associated with such injuries. The deformity caused by burns may cause the child to need to readjust his body image—not a minor task. To a six year old girl who was used to hearing other speak about her as "adorable" or "darling", the fact that her physical beauty is now marred by ugly scar tissue is a major roadblock to psychological adaptation and recovery.

The fact that the child's body image is modified after a burn injury is documented by Nover, who recounts a tale of a five year old who experienced no tactile sensation in his lower extremities. The child's reaction to the injury was one of indifference—in keeping with his body image, when asked to draw a picture of himself, he sketched only the upper half of a body.[22] Also using drawings in a projective manner, Vigliano et al. found that children perceived their own burned bodies as immature, inadequate, and weak. These children seemed overly concerned with the maintenance of bodily integrity. They concluded that many children have long psychiatric sequelae to burns.[8]

Psychotic Reactions

Quindlen & Abram[23] studied psychotic reactions among severely burned patients, and found them to be of three types:

1—schizophrenoid
2—associated with neurological damage
3—psychogenic

The first results essentially from maladaptation to the disfigurement caused by the burn. Neurologically-tied psychoses were usually toxic in quality and associated with delirium. The psychosis set in 2-4 days after the burn catastrophe. Seizures among type 2 patients were common, as were fatalities. The third type of psychosis generally has its roots in extreme anxiety due to the pain, or resulted from the inability to successfully adjust to the need for a revised body image or from a blurring of the boundary between self and non-self.

There is tentative clinical evidence that children's psychological reactions may follow a paradigmatic course as the hospital residence phase matures. Long & Cope observed that, at first, the child is usually reasonably co-operative, but later on he may become unco-operative, aggressive, and assaultive.

Martin studied burn victims continuously for the three months following the incident, and then at follow-up sessions three, six, and twelve months following the incident. During the first period, the most common reactions were detachment, protest, despair, and anger toward parents and care custodians. More severe psychological reactions were observed in children under the age of two years than in older children. The main problem for hospitalized children was that the separation resulted in a frustration of what we may call the "need for mothering" (and, in mothers, the "need to mother").

Early and middle term follow-ups found that the children's anxiety, though not as severe as it had been during the critical hospitalization phase, was still causing them problems, such as sleep disturbances (pavor nocturnus, somnambulism, ephialtes) and phobic and obsessive-compulsive behaviors, with themes of fire (counterphobia or reaction phobia) and cleanliness predominating. The most prominent feature discovered at long term follow-up was extremely intense sibling rivalry, for which there are any number of etiological explanations. In children under the age of 15 months, an unusual catatonic-like state was sometimes seen.

Reactions in Relation to Severity of Burn

Additionally, Martin points out that the degree of severity of the psychological reaction to the burn does not reliably correlate with the severity and/or extensiveness of the burn—some children who were only slightly injured experienced major psychiatric disorder. Some children from larger families found the hospitalization period to be agreeable, enjoying the meticulous attention paid to them as never before. Seligman et al.[2] discovered that the occurrance of ulcers, hypertension, and seizures were an interestingly reliable prognostic index—those patients who experienced them typically survived, while those who did not usually were among the mortality cases. Thus, the relationship between the capacity to physically experience tension and the severity of the burn injury appear to be related somehow.

Finally, in Woodward's survey of the mothers of burned children, 81% replied that they thought the child to be emotionally disturbed (mostly fears and anxieties) following the trauma. There did not appear to be any sex differ-

ences for this factor, but it was observed that more children under the age of five who were not visited often by their parents while hospitalized became disturbed.

Mental Health Prior to Incident

While it is clear that many burned children suffer disordering psychological traumata concommitant with the physical injury, an important related question deals with the mental health of such children prior to the burn episode. Savage & Leitch noted that at least 15% of the child burn victims they studied had been previously treated for other injuries in emergency rooms, as were 15% of their siblings. Of Holter & Friedman's 15 subjects, 5 (approximately 40%) were judged to be disturbed at the time of admission (including academic disabilities). It will be recalled that 3 of the 13 subjects were alleged victims of child abuse incidents. Long & Cope reported maladjustment prior to the burn incident in nine of their study children (53%). The problems included depression, delinquency, and general character disorders.

On the other hand, it will be recalled that 81% of Woodward's subjects were judged to be emotionally disturbed following hospitalization. However, only 17% of that 81% evidenced any disturbance prior to the incident. Fourteen percent of randomly selected, matched control children were judged to be similarly emotionally imbalanced, as were 7% of the siblings of the burned children. She concluded that it was the burn accident that accounted for the incidence of emotional disturbance in these children, and that it is not true that burned children represent a specially select population of children already disturbed.

Studies Used

As is usually the case in attempting to reconcile such diverse and seemingly antagonistic data, one needs to return to the studies themselves and examine the study populations, the experimental or observational methodologies, the data gathering procedures, and so forth. Holter & Friedman's selection of 13 subjects drawn from all children admitted to Strong Memorial Hospital with severe burns (at least 15% surface area, second and third degree burns) was reportedly based on considerations of "length of hospitalization and availability of parents."

Long & Cope drew 13 of their 19 study children from a group that was judged to be in need of and was receiving intensive psychiatric assistance. These are obviously not random samples but rather well-selected subjects drawn from specified subsets. One would not do well to assume that 40-53% represents a good estimate of all burned children who were emotionally disturbed prior to their injury, although these are the figures reported in various studies using selected samples and small numbers of subjects. Woodward's British sample, though, is significantly larger, consisting of 198 severely burned children, roughly 50% of all admissions under the age of 15 years old at the burns unit of the Birmingham Accident Hospital. More confidence can be placed in the results from such a study, since the sample appears to be far less selective.

Another obvious flaw in this type of investigation is the extremely imprecise method of evaluation. The only estimate of premorbid personality used has been judgment by mothers. Objectivity, hence, is almost totally absent. The present data must be viewed with this factor in mind, and therefore, cannot be taken as reliable guidelines.

Burns Not Always an Accident

Still, it has been suggested by others that burned children are not always the victims of pure accidents. Evidence such as Long & Cope's observations of severe emotional reactions to very slight burn injuries cannot be turned away unthoughtfully. Seligman et al. noted early parent loss as a significant premorbid event in a number of burned children. They also noted that certain dates appeared to have symbolic anniversarial significance in the children's lives. They suggest the possibility of unconscious motivation for the injuring incident.

I would align myself most closely with Kjaer, who suggests that, with some children, accidental injury of all types, including burns, may serve a significant function in the individual's personality makeup. The psychotic child is one type, but there are others who might exhibit such self-destructive character-oriented behavior.

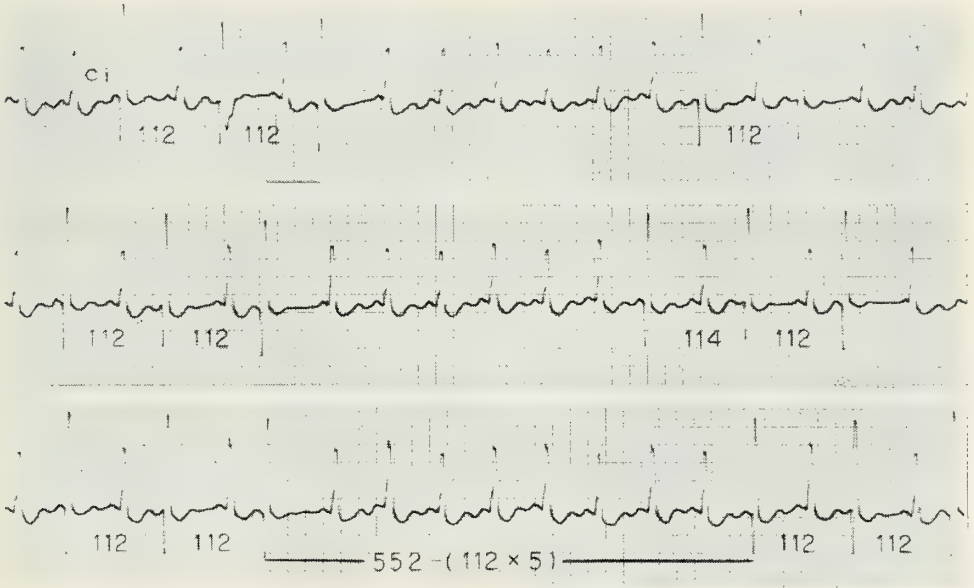
The intellectually retarded group is still another which might have a high incidence rate for accidental injury. Thus, what is needed is not so much a group of dubiously scientifically designed studies of children who have already been burned, but epidemiological investigations of some of the aforementioned groups, and others, which may be high risks for accidental injury in general.

(To Be Continued Next Month)

ekg of the month

John R. Tobin, Jr., M.S., M.D., Rimgaudas Nemickas, M.D., Patrick J. Scanlon, M.D., John F. Moran, M.S., M.D., Sarah Johnson, M.D., and Rolf M. Gunnar, M.S., M.D./
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

This sixty-four year old lady gave a history of an old anteroseptal wall myocardial infarction ten years prior to her current admission. She presented to the emergency service with a two hour history of severe crushing anterior chest pain. An ECG demonstrated an acute inferior wall myocardial infarction. One week later in the hospital, a loud pansystolic murmur was heard for the first time, and the patient developed congestive heart failure. During the medical treatment for heart failure, the arrhythmia shown developed. Subsequent cardiac catheterization confirmed the presence of a ventricular septal defect and coronary artery disease.



Questions:

1. The ECG rhythm strip shows:

A. Intermittent left bundle branch block.
B. Frequent premature atrial beats.
C. Frequent premature ventricular beats with fixed coupling intervals (ci).
D. Ventricular parasystole.
E. None of the above.

2. Which of the following statements are true?

A. The digitalis started for congestive heart failure should now be discontinued.
B. Intravenous lidocaine should be given.
C. Coronary care monitoring should be done.
D. The prognosis of patients with this arrhythmia is grave.
E. All of the above.

(Continued on page 533)

Relative Severity of Hemolysis in the Subtypes of ABO Incompatible Hemolytic Disease

By Shatchai Seungdamrong, M.D. and Shig Yasunaga, M.D./Urbana

This investigation demonstrates that hemolytic disease among infants of ABO incompatible pregnancies is more severe in B infants. Sensitivity of the fetal red cells to isoantibodies is possibly the important aspect in the pathogenesis of ABO hemolytic disease. The discrepancy of the severity of hemolytic disease seen in this study is possibly due to a uniform antigen strength in type B infants binding more readily with the isoantibodies than those of A infants. A significant number of group B infants were exchange transfused in comparison with group A babies.

Introduction

The incidence of hemolytic disease among the infants of ABO heterospecific pregnancies is very low when compared to the outcome of Rh incompatible pregnancies. Approximately 20 to 25% of all pregnancies are heterospecific in that fetal red cells possess the agglutinogen A or B not present in the mother, while the maternal serum contains the corresponding agglutinins which are antagonistic to the fetal blood cells. Observations of several authors[1,2,3] revealed better predicators of involvement in hemolytic disease among the infants of ABO heterospecific pregnancies. Occurrence of the hemolytic disease is almost exclusively in type A1 and B infants; type A2 infants were seldom affected by the disease. The present report further defines the role of the fetal red cells in determining the susceptibility of infants to hemolytic disease.

Material and Methods

Subjects were selected from the newborn infants born at the Jefferson-Davis Hospital, Houston, Texas, during the period from October, 1971 to March, 1972. All were full-term infants of blood type O—Rh-positive mothers and had no major morbidity at birth. Those who later developed either respiratory complications or clinical manifestation of perinatal infections were excluded from this series.

All infants admitted to the nursery routinely had cord blood specimens sent to the laboratory for ABO and Rh typing and direct antiglobulin tests. Cord blood bilirubin levels were also determined on those infants who appeared icteric upon initial examination. Each infant was examined daily for clinical jaundice, and serum bilirubin concentrations were determined on those who appeared jaundiced and were repeated at 12 to 24 hours intervals. Peripheral blood smears, hematocrits and reticulocyte counts were obtained from icteric infants to assist in the diagnosis of hemolytic disease.

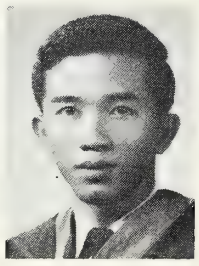
Exchange transfusions were performed on those infants who manifested signs of severe hemolysis. Criteria for exchange transfusion were those outlined by McKay, Jr.[4] as follows: at birth exchange transfusion for maternal antibody titer > 1:64; cord hemoglobin 12-14 gm/100 ml.; cord bilirubin 4-5 mg/100 ml. After birth: capillary blood hemoglobin < 12 gm/100 ml., and serum bilirubin 18-20 mg/100 ml. must be considered. Phototherapy was applied on those babies who had serum bilirubins over 10 mg percent and discontinued when the serum bilirubin level declined to a level below 10 mg percent.

Results

During the study period, 4,904 infants were admitted to the nursery. Of these, 1,404 infants were from group O, Rh-positive mothers, including 969 group O infants, 295 group A and 140 group B.

Significant jaundice with serum bilirubin concentrations over 10 mg percent, in the first 3

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days of life was observed in 197 (14%) group O infants, 101 (7.2%) group A infants and 48 (3.4%) group B infants (Table 1). Direct antiglobulin test was positive in 119 group A infants, 67 group B infants and none in group O infants. Two of the O infants, 5 of the A infants and 9 of the B infants required exchange transfusions.

Statistical analyses of Table 1 showed that the infants of heterospecific pregnancies had higher incidences of jaundice, positive antiglobulin test and exchange transfusion than those of homospecific pregnancies ($p < 0.005$). A significant difference in the incidence of exchange transfusion was found between group A and B infants. The type B infants were more severely affected by the hemolytic disease than A infants ($X^2 = 5.39$, $p < 0.05 > 0.02$). The incidence of positive direct antiglobulin test was slightly higher in B infants but this was not significant statistically. The incidence of jaundice was not significantly higher in A infants.

Table 1

Outcome of the infants of ABO incompatible pregnancies. (Group O, Rh Positive Mothers)

Infants' blood type	Total No. of infants	Number of infants with: Serum bilirubin >10 mg%	Positive antiglobulin test	Exchange transfusion
O	969	197	0	2
A	295	101	119	5
B	140	48	67	9

Discussion

This investigation demonstrates that hemolytic disease among the infants of ABO incompatible pregnancies is more severe in B infants. The incidence of significant jaundice (> 10 mg%), however, is approximately the same among A and B infants. This might be attributed to the failure to segregate those infants according to their peak serum bilirubin. However, upon evaluation, B infants showed more severe involvement, as evidenced by higher incidence of exchange transfusions.

Sensitivity of fetal red cells to isoantibodies is probably the important aspect of the pathogenesis of ABO hemolytic disease. Gunson[5] observed that sensitization of the infants' red cells could occur without clinical manifestation of the disease. This observation is explained by the findings of Fischer et al[6] that the maternal ABO antibodies which have reached the child via placenta bind differentially with the erythrocyte population.

Witebsky and colleagues[7] demonstrated that cord blood cells of babies belonging to blood group A revealed wide variations of agglutinability. About half of the babies' red cells reacted like adult A2 cells or even weaker. The other half reacted between adult A2 and adult A1 cells. Differences between A1 and A2 cells are primarily in the numbers of antigen sites.[8] A1 adult cells have more A sites than A2 adult or infant A cells and A2 adult cells have comparable numbers of A sites to A1 infant cells. Thus the average distance between A sites must be greater on infant A1 cells than on adult A1 cells. This difference may be an important factor which determines the agglutinability of the cells.

Subgroups of type B cells are rare.[9] However, variation in the strength of B antigen within blood type B does exist.[10] The Caucasoid cells possess only 60 percent of the agglutinability of Negroid cells. Although the detailed study of antigen strength of B cells among newborn infants is not established, this may very well occur in B cells of neonates and help explain those B infants with positive direct antiglobulin test who never demonstrated signs of hemolysis or had had only mild hemolysis.

The discrepancy in severity of hemolytic disease seen in this study is probably the result of varied affinity of infants' red cells to maternal isoantibodies. Antigen strength of type B infants in this group of population is probably more uniform and binds more readily with the isoantibodies than those of A infants.

Summary

The incidence of clinically significant hemolytic disease among the infants of ABO heterospecific pregnancy is 24.5%. A significant difference in the frequency of exchange transfusions was found between A and B infants, B infants being more severely affected by the hemolytic disease than A infants ($X^2 = 5.39$, $p < 0.05 > 0.02$). The discrepancy of severity of hemolytic disease seen in this study is probably the result of varied affinity of infants' red cells to maternal isoantibodies. ◄

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(Continued on page 530)

The Demise of the Hopewellian Moundbuilders

A Plausible Conjecture

By Hugh A. Johnson, M.D./Rockford

The archaeologist's chief concern with contagious disease today is the innoculations before leaving for a dig. I wonder how often he or she speculates as to the part those same diseases (against which he or she is being innoculated) played in the demise of the civilization whose postmortem is the dig?

Isolated civilizations often have no natural or acquired immunity to newly introduced diseases. The "great pox" syphillis (as opposed to the smallpox) spread as an epidemic through Europe in the 15th century; noses and palates melted away, even Henry VIII suffered from a draining gumma, and daughter Elizabeth seemed to bear the stigmata of congenital syphillis. But gradually syphillis became the relatively mild disease it is today as Western man built up immunity. Measles decimated the Polynesians. The unique tribe of "white Indians," the Mandans, was wiped out by smallpox brought by frontiersmen in the middle 1800's.

For a moment let's consider another population that suddenly disappeared without a plausible explanation, Fatipur Sekri, a lost city near Agra, now beautifully preserved and restored. It appears to me, a romantic, as though the Muslims merely packed up and left. There is no actual record as to why the city was abandoned, even though these people were most literate and recorded everything. Every account I've read postulates that the water supply gave out, so the city was abandoned. It is hard for me to accept that when I see the engineering feats, the Qtab Minar and the fountains at the Red Fort in Delhi. The river in Agra is but 90 miles away. With the same Hindus (and whips,) the men who built the Taj surely could have managed a canal; witness the age-old Qnat, the underground aqueducts in Iran that span distances of over 40 miles, dug up to 300 feet underground by predecessors of the men who built Fatipur Sekri.



Figure 1. The great bear mound in the Effigy National Monument. Well worth a visit for all those interested in the Hopewellian Culture.



Figure 2. Smaller effigy mound.

The Black Death

Fatipur Sekri faded without written record at the time plague was sweeping the world in catastrophic proportion in the 14th century. Plague (also called Black Death, probably for the widespread petechiae that sometimes occurred antemoretem) appeared and was pandemic worldwide, in China, India, the Middle East (Russian graves say 1338) and Europe (estimated 25,000,000 died there.) From a quarter to three-quarters of the population died, depending on which estimate one reads. People fled the cities. Samuel Pepys describes vividly the exodus from London in a later pandemic. Why wouldn't the residents of Fatipur Sekri flee from the wrath af Allah, as did Londoners, Florentines, etc.? This would explain the lack of records.

The spread of plague (vide infra, for more detail) is rat to flea to man (bubonic) or man to



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man (pneumonic). Ratus norvegicus, rat that travels by ship, is the chief culprit. At about the time of the worldwide spread of plague, the Norsemen were traveling regularly to their outposts in Greenland (there was even a bishop of Greenland; these settlements persisted until the 15th century raid of the English pirates made life unbearable.) But the "long ships" (and their rats) went far beyond Greeland to the settlements of Hudson's Bay, and the Norsemen left their ships, even on foot to Kensington, Minnesota, the site of the Rune stone.

This might have been the fatal point of contact. The Norsemen might not have left only their genes with the "white" Mandan Indians but might also have left Yersinia (Pasteurella) Pestis, the causative organism of plague. The rats did not survive. We now know there might have been human carriers of pharyngeal plague left behind. These have been identified in Viet Nam. Such carriers could have caused the spread of the pneumonic form of plague. In Viet Nam disruption of Public Health measures by the Viet Cong had given me an opportunity to study a case (see Fig. 3). Sylvatic plague—but I'd best stop for a brief resume of the disease and some definitions in order to make my conjecture more logical, or more plausible.

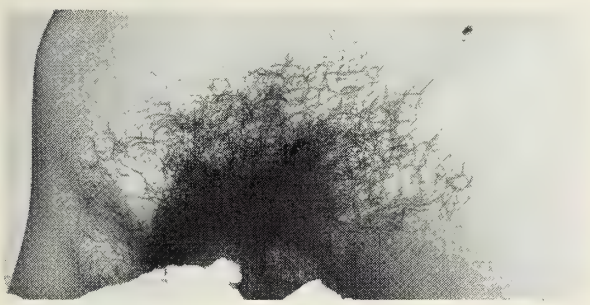


Figure 3. Buboes in the inguinal region of Vietnamese with bubonic plague, April 1974.

Origin of the Plague

Plague bacilli grow in the gut of the flea and obstruct it. When the hungry flea sucks blood, the flea regurgitates organisms into the bite wound. Its feces also contain organisms and can be rubbed into a break in the skin. (Body lice and ticks also can serve as vectors.) The lymphatics pick up the organisms which then settle in the lymph nodes, usually those in the groin. These nodes enlarge and sometimes ulcerate and drain. The enlarged nodes are the "buboes". The modern or vernacular term "buboes" is applied to the enlarged groin nodes in the venereal infection lymphogranuloma venereum. Buboes in street language has been corrupted to "blue balls."

Within hours of the onset of generalized plague symptoms the patient is profoundly ill with temperatures of 103° and 104°. He soon becomes delirious, then comatose, and purpuric spots (small skin hemorrhages) may appear. Probably this pigmentation gave rise to "black plague". In cases in Viet Nam it was found that if treatment with antibiotics was not started within the first few hours after the onset of the high fever the disease was invariably fatal. Pneumonia features prominently in the disease, and exhaled droplets can spread the disease, hence the cases contracted in this fashion have pneumonic plague (invariably fatal). Carriers of plague in the pharynx were discovered first in Viet Nam. There the mortality of clinical cases seen was 20-60%. I strongly suspect that with the state of nutrition in previous centuries mortality would have been greater.

Only the relatively more recent epidemic "plagues" were accurately chronicled. To illustrate the rapidity of spread, in December, 1664, the first recorded death from plague occurred in London. (In 1663 it ravaged Amsterdam.) By April, 1665, Samuel Pepys wrote, "Great fears of the sickness here in the city, it being said that two of three houses are already shut up." By June, everyone who could had left London. Couldn't the same have been true of the Mound



Figure 4. Fatipur Sekri near Agra, built by the dynasty that built the Taj Mahal. This Muslim City has been deserted since the time of the pandemic plague in the 14th century.



Figure 5. Fires were lit to try to purify the air of the London streets, and once a house had the dreaded cross on it few would enter.

Builders? From where did the fierce tribes come, which historians postulate wiped out the Mound builders widespread civilization. And to where did these fierce and powerful tribe vanish?

Sylvatic Plague in America

Now a bit about sylvatic plague in America. Plague is found in our woodland creatures, field mice, squirrels and other wild rodents. Wild rodent fleas rarely bite man and only accidentally those who are in close contact with squirrels or prairie dogs; persons such as sheep herders, linesmen, campers. The speed of air travel has resulted in clinical cases considerably distant from the site of contact. Caten and Kartman state that sylvatic plague has never spread to our urban rats.

Where did this endemic plague come from? We can only speculate when it came to America. Apart from two epidemics in San Francisco (1900-1904 and 1907) accounting for 432 cases with 284 deaths, there have been only 115 cases of plague in the U.S. from 1908-1966, these sporadic and spotty in distribution.

Has this sylvatic plague been the legacy of the moundbuilders? Did they flee their complicated stockades to die in the forests? Did their fleas and lice take as hosts the wild rodents that came to consume their plague-wracked bodies? Unfortunately the disease is so rapidly progressive to death that no skeletal changes are left for the archaeologists. The organism is destroyed by sunlight and leaves no spores, so cultures of gravesites would do us no good. Thus we have no true circumstantial evidence, but merely, to me, what seems a more plausible conjecture as to the fate of these advanced moundbuilding cultures.

The Hopewellians, builders of great burial mounds and earthwork systems, apparently disappeared about A.D. 1300. The Mississippians, whose mounds resembled those of the Mexican civilizations, replaced the Hopewellians, reached their peak and disappeared between A.D. 1300 and 1500. The timing is right, for plague had spread around the rest of the world, and dated carbon from the Norse settlements proves that a means of the demise could have been brought to the New World by the Norsemen. Will we ever know? Perhaps the secret is in some undeciphered ruins hidden somewhere here in the New World.



Figure 6. Corpse bearers were in constant danger of contracting the disease. Deaths exceeded 100,000 in London 1665.

Relative Severity of Hemolysis

(Continued from page 527)

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Digitalis as Treatment for Pulmonary Comsumption, 1799

By Ronald D. Greenwood, M.D./Boston

After the discovery by Dr. Withering of the medicinal qualities of Foxglove or Digitalis, much was written regarding its proper and improper use.

Dr. Nathan Drake used it to treat "pulmonary consumptions"*. He relates his theories in prescribing this drug for such cases:

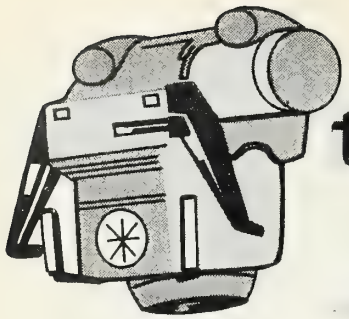
> It has been lately maintained by the most** celebrated physiologists, among whom John Hunter stands foremost, that pus is a secreted fluid, the consequence of certain diseased motions of the extremities of the blood-vessels; it has been likewise ascertained, that hectic fever arises only from the matter of an open ulcer; that what is termed laudable pus, when secluded from the air, is neither capable of creating fever, nor, except by its gravity, can it irritate the parts on which it rests. When pus, however, is exposed to atmospheric air, it rapidly attracts oxygen, an acid of a peculiar kind is generated, and hectic fever, the effect of the absorption of aerated matter is produced. Now as an ulcer of the lungs is perpetually exposed to a stream of air, and of course an ichorous poison continually forming by the union of oxygen with secreted matter, an important curative process would seem to arise from promoting absorption so rapidly from the surface of the disease parts, that the pus shall be taken up as soon as secreted, and consequently its combination with oxygen prevented. If at the same time the medicine employed to promote absorption, should so powerfully retard the motion of the heart and circulatory fluids, that the irritating and morbid action of the extremities of the blood vessels, and therefore secretion as its immediate effect, should be considerably diminished, if not altogether suspended, another most salutary purpose would be accomplished. To the cautions and continued use of digitalis, Sir, I looked for these consequences, though whether I should be able to render them sufficiently permanent to promote a cure, was necessarily a matter of great doubt. It was my wish also, as I have mentioned above, to effect these changes without any previous sickness, concluding that should I be able gradually to depress the circulation, nausea, as a link in the chain of effects, might be excluded, and absorption, together with a suppression of morbid action and secretion, still be the result.
>
> It is a well-known fact and probably arising from an indissoluble association between the stomach and the heart, that the pulse generally sinks in consequence of nausea; and as subsequent to the retardation of the action of the heart, absorption frequently occurs, it has been supposed that nausea, a diminution of arterial motion and absorption, are mutually and necessarily related to each other, and that were the first of these phaenomena abstracted, the latter, viz. absorption, would not be produced. It has therefore been usually attempted to promote pulmonary absorption, through the medium of this affection of the stomach, whence the the prescription of emetics, of sailing at sea, and of swinging, to induce vertigo and sickness; and the digitalis has been hitherto athibited with this view. The cases annexed, however, will prove that the circulation may be safely, powerfully, and perhaps more permanently retarded, independent of any affection of the stomach, and that absorption as cartainty follows a depression thus procured, as when sickness has ushered it in."

Dr. Drake felt this treatment was "permanently successful" in some cases.

*The Medical and Chirurgical Review 6:148-153, 1799 (London).
**to make the quotation readable, all f changed to s e.g., most in original was "moft" etc.

Acknowledgement

I am indebted to the Francis A. Countway Library of Medicine, Harvard Medical School for use of historical materials.



the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

Aqueductal Stenosis and Parinaud's Syndrome

By Behrooz Azar-Kia, M.D., F.R.C.R., Enrique Palacios, M.D., and Robert Churchill, M.D.

Parinaud's syndrome is one of the ocular abnormalities that has been reported in aqueductal stenosis. Localization of a lesion to the tectum or posterior commissure should include aqueductal stenosis in the differential diagnosis.

Aqueductal stenosis in adults has been associated with certain patterns of symptomatology such as impaired memory, epilepsy, unsteady gait, symptoms of increased intracranial pressure, and endocrine disorders.[1] Reference has also been made to various ocular abnormalities observed in patients with aqueductal stenosis called the Sylvian aqueduct syndrome.[2] Parinaud's syndrome, conjugate ocular paralysis of upward gaze, is one of these abnormalities and has been described in patients with aqueductal stenosis.[1-4]

The following case report illustrates the importance of this sign in a patient who had previously carried a diagnosis of a demyelinating disorder.

Case Report

A 64 year old right handed male chemist presented with complaints of epigastric pain, unsteadiness of gait, and having to drag his right leg when fatigued. He stated that his gait had not gotten progressively worse over the five years that he has had this problem; however, a review of his records from a hospitalization at another institution two years prior to this admission revealed that his signs had become more extensive. His work up at that time included a normal cerebral angiogram and normal myelogram. He was felt to have a demyelinating disorder and received ACTH and steroid therapy with some clinical response. His past history was otherwise non-contributory except for his occupational exposure to chemicals and metals.

The physical examination at this time revealed truncal ataxia and a staggering gait. He had a tendency to fall toward the right and backwards and he swayed while sitting. Muscle stretch reflexes were increased on the left and plantar responses were neutral. Muscle strength was normal and all sensory modalities were intact. There was a left supranuclear facial weakness. He had paralysis of convergence and the pupils did not react to light. There was impairment of upward gaze with some nystagmus. The optic discs were flat. The mental status examination was normal. The patient was felt to have a lesion in the midbrain in the area of the superior colliculus.

The patient had a normal CBC, SMA_{12}, CSF, GTT, VDRL, screen for toxic metals, and EEG. The EKG showed atrial fibrillation with a controlled ventricular response and a gastrointestinal study with barium revealed a duodenal ulcer. Hydrocephalus was demonstrated on cerebral angiography. Pneumoencephalography was performed and there was failure of the air to fill the third ventricle. A well defined, round mass density was outlined by air in the quadrigeminal cistern (Fig. 1) suggesting a mass in the region of the pineal with obstruction of the aqueduct.

Air ventriculography revealed moderate dilatation of the lateral and third ventricles with failure to fill the fourth ventricle. The proximal third portion of the aqueduct was markedly dilated by a complete obstruction; no definite enlargement of the pineal recess of the third ventricle was demonstrated (Fig. 2). The dilated aqueduct was the round mass seen in the quadrigeminal cistern on the pneumoencephalogram.



Figure 1. The pneumoencephalogram shows lack of filling of the third and lateral ventricles by what appears to be a rounded mass in the region of the quadrigeminal plate.

The patient was felt to have aqueductal stenosis of the membranous type. He subsequently had a shunting procedure resulting in marked improvement.

The association of Parinaud's syndrome has been previously reported in aqueductal stenosis.[1-4] The mechanism by which this is said to occur results from the tectum and posterior commissure being compressed between the dilated suprapineal recess of the third ventricle above and the dilated aqueduct below.[1-3] This area of the brain contains the centers and pathways for cojugate upward gaze, pupillary responses, and convergence. Our patient did not have a dilated suprapineal recess. We therefore feel that the localized dilatation of the aqueduct was the only cause of the compression of the tectum causing the ocular changes. It has also been pointed out that the appearance of Parinaud's syndrome in patients with shunts for aqueductal stenosis is an early sign of shunt failure.[4]



Figure 2. The air ventriculogram demonstrates a complete occlusion of the aqueduct with a globular dilatation of its proximal portion.

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EKG

(Continued from page 525)

Answers: 1. D 2. B,C

The tracing shows frequent ventricular premature beats with unequal coupling intervals (ci). The presence of variable coupling intervals plus a consistent, shortest, interectopic interval (1120 milliseconds) make the diagnosis of ventricular parasystole and imply a protection block around this independent ventricular focus. It can be seen in line three of the rhythm strip that the constant interectopic interval holds even over long cycles (5x112). Fusion beats are frequently seen in this setting but are not necessary to the diagnosis if variable coupling intervals and constant interectopic intervals are present. In the setting of recent myocardial infarction, intravenous lidocaine would be recommended as well as ECG rhythm monitoring in the coronary care unit.

There is no firm relationship between digitalis and ventricular parasystole. In fact, treatment of heart failure with digitalis has eliminated the arrhythmia in some cases. Ventricular parasystole is relatively uncommon, occurring in 4.1 percent of a recent series with myocardial infarction (Baxter *et al. American Heart Journal* 88:443-8, October, 1974). All fifteen patients in that series survived. The prognosis of ventricular parasystole is related to the underlying heart disease. It has even been reported in patients with no evident heart disease although most cases have evidence of organic heart disease, primarily coronary artery disease and/or hypertensive cardiovascular disease.



Time, Money and the Housestaff Officer

The "Housestaff News" is designed for interns and residents. News items and short articles of interest to housestaff will be considered for publication; materials should be sent to Michael Hughey, M.D., 711 Laurel Avenue, Wilmette, Ill. 60091.

By Michael Hughey, M.D.

With the growing number of housestaff organizations and the increasing use of the bargaining table to determine housestaff contracts, two items have become dominant issues, time and money. The well-publicized confrontations between housestaff and administrations in hospitals in New York, Chicago and Los Angeles have resulted in open discussions of these and other factors. Many arguments for more or less time or money for housestaff have been presented, with each proponent claiming for his own cause the concepts of fairness, fiscal responsibility, and quality of patient care.

Some of these arguments cite the experience of other housestaff officers of years past who worked thousands of hours per week for little or no reimbursement. One typical example might involve a physician who twenty years ago as a housestaff physician was granted four hours *off* per week, and then only if the hospital was quiet. For his service he was reimbursed with free uniforms, one free meal a day, and twenty-five dollars a month. While some would hold that he received excellent training and suffered no permanent ill effects from this experience, others maintain that this is an example of barbarity and indentured servitude of the worst form.

The use of examples such as this serves no useful purpose in the discussions of today, other than to give some historical perspective to the problem. The fact that a situation existed in the past does not mean that that situation must be sustained forever. Nor does it mean that because a situation existed twenty years ago, it is necessarily bad. What it does mean is that in the past, when social and economic structures were quite different from today, many physicians received post-graduate training that placed enormous demands on their physical and mental stamina for very small immediate rewards. That most of these physicians survived that training and are very happy today no more justifies that experience than any similar results of war, bubonic plague, the Spanish Inquisition or other historical events.

What *is* relevent to today's discussion are the factors at work in today's social and economic structure. At the same time that the housestaff physician is playing a more important role in delivery of patient care, particularly in large urban hospitals, the financial solvency of these institutions is ever diminishing. Thus, the program directors and hospital administrators are increasingly anxious to obtain the most amount of service from housestaff for the least amount of money. For this, they cannot be faulted, particularly in these days of financial troubles.

However, the wishes of the hospital administrators and program directors are not identical to the wishes of housestaff physicians, and in fact, may be miles apart. Housestaff physicians, like any other group of human beings, desire the best possible patient care and individual training for the least amount of personal time expenditure and the most amount of financial reimbursement. They cannot be faulted for these desires, for these values are basic to our economic system. When the two groups of individuals sit to discuss their differences, conflict inevitably arises.

Housestaff officers are quick to point out in these discussions that spending 120 hours per week in the hospital (as some, but not many, do) is barbaric and places undue physical and mental strain on physicians who are making potentially life and death decisions minute by minute. The housestaff physician who has gone 50 hours without sleep cannot deliver quality medical care to his patients and is likely to make serious errors in medical judgement. Notwithstanding the issue of medical care, one can seriously question the effects on mental status and the health of a housestaff physician's family or social life when such demands on his time are made.

Hospital administrators and program directors are quick to point out that even in those few cases where housestaff do spend this inordinate amount of time in the hospital, not all of that time is involved in patient care. Certainly, time spent asleep in the call-room is not the same as time spent scrubbed in surgery. In addition, they maintain that it is exceedingly difficult to learn the true course of disease when observing that disease on a nine-to-five basis.

The arguments on both sides of the time issue are unquestionably valid. Certainly, the ideal amount of time to be spent inside the hospital lies somewhere in between the two extremes and undoubtedly varies from specialty to specialty and from clinical setting to clinical setting.

The question of salaries, stipends, financial reimbursement and other such fiscal details also occupies a great deal of time in discussions of housestaff contracts. Many housestaff contend that in view of the professional services they render, they are considerably underpaid. Many hospital administrators and program directors contend that in view of the amount of teaching and other training they receive, housestaff are not only overpaid, but probably they should pay the hospital for the training they receive. There are valid points on both sides of the issue.

The fair market value of housestaff services can be estimated from such moonlighting activities as emergency rooms where rates vary, but about $15 an hour is typical. If a housestaff physician were to spend his 80 hours a week in strictly patient-care activities, a fair reimbursement for his time would be about $1200 a week or $58,800 a year (counting vacation). However, few if any housestaff physicians spend their in-hospital time involved in strictly patient-care activities.

The fair market value of educational activities can be estimated from the many post-graduate review courses which frequently charge about $150 for about 20 hours

(Continued on page 557)

Doctor's News

WALKER VETO "SEVERE SETBACK" FOR MD POLICING EFFORT—ISMS President Dr. J. M. Ingalls chided Governor Walker for "ignoring the concern of the public and medical profession" over activities of unscrupulous and incompetent physicians. Dr. Ingalls charged the governor with trying "to preserve a grossly inadequate status quo in the Department of Registration and Education." Unless incompetent physicians are "weeded out," he warned, professional liability insurance rates will continue to soar and the public will pay through higher physician fees and a decrease in availability of care. Late word indicates that on Nov. 5, the Illinois House of Representatives overrode.

SHORTAGE OF FAMILY DOCTORS STILL A PROBLEM, says the Coordinating Council on Medical Education (CCME). This new group, a parent organization of five major associations concerned with medical education, draws these conclusions in a report entitled "Physician Manpower and Distribution, the Primary Care Physician." The CCME believes this shortage of primary care physicians will get worse unless something is done. For copies of their report with recommendations for improvement of this situation write: Dr. C. H. William Ruhe, Secretary of the CCME, P.O. Box 7586, Chicago 60680.

THE KIWANIS INTERNATIONAL FOUNDATION HEARING RESEARCH PROJECT was dedicated on October 4, at Chicago's Mercy Hospital and Medical Center. This project was designed to develop new procedures for testing the hearing of infants and children as well as that of the emotionally disturbed and mentally retarded and is made possible through the efforts of the Kiwanis International Foundation and the American Hearing Research Foundation. Research into hearing impairment will be carried on in a new laboratory containing specially built equipment which tests electrical activity in the hearing organ and the hearing nerve.

SPECIAL SERVICES FOR DISABLED—Illinois Bell waives certain charges for disabled persons who have difficulty in placing telephone calls without the help of an operator. To qualify, disabled customers should call their nearest Illinois Bell Business Office and ask for a certification form.

SUPPORT OF MEDICAL PROFESSION REQUESTED—The National Heart and Lung Institute announces the initiation of patient recruitment for a new National Cooperative Clinical Trial, the Aspirin Myocardial Infarction Study (AMIS). AMIS is seeking to enlist men and women, aged 30-69, who have sustained a documented myocardial infarction no less than 8 weeks or more than 60 months prior to entry into the study. Inquiries about the study and a list of practicing clinical centers may be obtained from: Dr. William Friedewald, Project Officer, AMIS Study, National Institutes of Health, Bethesda, Maryland 20014.

HYPERTENSION WORKSHOP—A group of leading physician/academicians are participating in this new learning system presented as a service to the profession by USV. The program is available in three parts: documentary film, detailed monograph and self-evaluation. Its purpose is twofold: to help classify hypertensive patients and to plan therapies more easily. For further information write: Medcom, Inc., 2 Hammarskjöld Plaza, New York, N.Y. 10017.

PHYSICIANS RADIO NETWORK BEGINS 24-HOUR OPERATION IN CHICAGO—This private broadcast station will operate on a subsidiary frequency of radio station WEFM and can only be heard on a special radio. PRN is distributing 1500 of these radios to practicing physicians in the Chicago area without charge. The PRN Broadcast day is divided into hour-long programs which are devoted to news from national medical centers and scientific meetings as well as programs on various aspects and specialties of medical practice.

PRN, a national network of radio stations linked together to keep the practicing physician abreast of the latest development in diagnosis and treatment of disease, is made possible through the support of six pharmaceutical firms: CIBA, Eli Lilly, Merck Sharp & Dohme, Smith Kline & French and Warner/Chilcott.

PHYSICIANS IN THE NEWS—**Donald B. Frankel, M.D.**, Chicago, has been named president of the Flying Physicians' Assn. New president of the College of American Pathologists is **Dennis B. Dorsey, M.D.**, Winfield. Other Illinois physicians recently elected to hold office are: **Herbert S. Ratner, M.D.**, Oak Park, President-Elect of the National Federation of Catholic Physicians' Guilds and **John W. Ditzler, M.D.**, Chicago, President of the American Society of Anesthesiologists.

John S. Graettinger, M.D., dean of faculty affairs for Rush University, has been named to the additional post of Director of Graduate and Continuing Medical Education for Rush-Presbyterian-St. Luke's Medical Center.

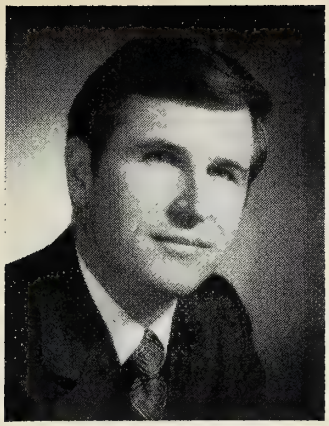
Three new physicians have joined the staff of The Children's Memorial Hospital, Chicago. **Dr. Douglas Stephens, D.S.O., M.S., F.R.A.C.S.**, an internationally known pediatric surgeon and urologist from Australia has joined the division of urology. **George R. Honis, M.D.** is the new head of the division of pediatric hematology and oncology. He comes to Children's from the University of Illinois Medical Center. **Carl E. Hunt, M.D.**, has been appointed as the first head of the division of neonatology.

Eugene R. Balthazar, M.D., will be honored November 25 as the 1975 recipient of the Stritch Medal of Loyola University of Chicago. Since he retired as a family doctor three years ago, Dr. Balthazar has been active as a general practitioner in a storefront medical clinic he opened in Aurora. He treats only the underprivileged and refuses to accept financial assistance. Often Dr. Balthazar sees as many as 100 patients a day.

Mr. Louis Gdalman, R.Ph., Director of the Pharmacy Section of the Department of Internal Medicine, Rush-Presbyterian-St. Luke's Medical Center, retired on September 1, after 45 years of service. Mr. Gdalman is a consultant to the Therapeutics Committee of ISMS.

Frank R. Hendrickson, M.D., chairman of the department of therapeutic radiology at Rush-Presbyterian St. Luke's Hospital, Chicago, was named president-elect of the American Society of Therapeutic Radiologists at its recent annual meeting in San Francisco.

Herman Wing, M.D., director of Physical Medicine and Rehabilitation at Illinois Masonic Medical Center, Chicago, has been appointed to serve on a special advisory panel of the Food & Drug Administration to develop manufacturing standards for review of all electromyographic equipment. Dr. Wing is also serving as a member of the Food & Drug Administration's Medical Devices Panel. The FDA, through this panel, is now reviewing methods for approving medical devices in addition to therapeutic drugs.



President's Page

Definitions for the '70s

The passage of time and corresponding changes in society frequently alter the definitions of commonly used terms. To alleviate possible confusion, I offer several "redefinitions" for the '70s. Admittedly, these "redefinitions" were formulated with a more jaded view than Webster might have employed.

Doctor: Individual who has completed educational requirements and has been awarded a high degree, e.g.: doctor of philosophy, dentistry, law or medicine.

General term not meant to infer *specific* talent or knowledge.

M.D.: Individual who received his M.D. degree and may or may not be involved in direct treatment of patients.

Often involved in research, administration or government.

Member of a non-unitable group which has a wide range of interests and marked diversity of opinion.

Legislative "fact-finding" committees often rely upon "authoritative" testimony of M.D.'s despite the fact they often lack direct experience in area of testimony, e.g.: academic MD testifying about rural bedside medical care.

Physician: Holder of an M.D. degree who is involved in patient care.

Seldom called on to testify at legislative committee hearings, but frequently referred to in statistical studies and used as target by those unhappy with the "establishment."

Commonly known as "provider."

Legislator: Individual elected by the people to consider and effect legislative solutions to concerns of society.

Inundated by mushrooming number of legislative proposals and currently unable to assure that legislation is implemented in intended form.

Desperately needs factual data from concerned persons, and is willing to accept ideas and discuss proposals.

Bureaucrat: Non-elected individual who implements legislation through government regulations. Member of most rapidly growing segment of state and federal government.

Has low public visibility and usually remains in job regardless of which political party controls government.

Attempts to justify actions through use of studies, data, computer printouts, and new committees.

Often very intelligent but usually has no experience in area affected by regulations. Very hesitant to become involved with anyone other than fellow bureaucrats because of fears this could cause reevaluation of pet assumptions and concepts.

J. M. Ingalls, M.D.



Diarrhea can hook anyone. When it does, physicians and patients both want prompt control of diarrheal symptoms. Lomotil will usually control diarrhea promptly.

This rapid action can halt the emergency aspect of diarrhea and is comforting and reassuring to the patient. Electrolyte and fluid losses can be corrected while the specific cause of the diarrhea is being determined. If an infective agent is the cause, appropriate specific therapy should be given along with Lomotil.

Lomotil is contraindicated in children less than 2 years old.

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TABLETS LIQUID

Each tablet and each 5 ml. of liquid contain: diphenoxylate hydrochloride 2.5 mg. (Warning: May be habit forming), atropine sulfate 0.025 mg

holds the line.

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or Narcan® (naloxone HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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DeHaen

(Continued from page 500)

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Indications: Topical osmotherapy of corneal turgescence.
Adverse Reaction: Slight transient stinging sensation.
Supplied: Plastic dropper bottle, 15 ml.

COMBINATION PRODUCTS

OS-CAL Plus Vitamin-Mineral Supplement o.t.c.
Manufacturer: Marion Laboratories, Inc.
Composition: Calcium 250 mg.
Ergocalciferol 125 USP Units
8 Vitamins and minerals
Indications: Multivitamin and multimineral supplement.
Dosage: One tablet t.i.d. before meals.
Supplied: Tablets

POLYCIN Antibiotic Ointment o.t.c.
Manufacturer: Dow Pharmaceuticals
Composition: Each gram of the ointment contains:
Polymyxin B. Sulfate 8,000 U.
Zinc Bacitracin 400 U.
Indications: Short term treatment of superficial skin infections caused by bacteria susceptible to bacitracin and polymyxin.
Warning: Prolonged use may result in overgrowth of nonsusceptible organisms.
Dosage: Apply 2 or 3 times daily.
Supplied: Tube, ½ oz.

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Opinion & Dialogue

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner, Food and Drug Administration



The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

Dr. James H. Sammons
Executive Vice President of the American Medical Association



I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

Mitral Valve Prolapse in Sarcoid Heart Disease

By Kayode A. Shenkoya, M.D.; Warren F. Walsh, M.D.;
Raul E. Falicov, M.D., and Leon Resnekov, M.D./Chicago

Echocardiographic and angiocardiographic confirmation of mitral valve prolapse in a thirty-seven year old black male, barely nine years after he was proven to have sarcoidosis by mediastinal lymph node biopsy, suggests possible infiltration of the mitral valve apparatus by sarcoid. The clinical picture of recurrent cardiac failure, ventricular ectopic beats as well as the documentation of a left ventricular apical aneurysm by angiocardiography also buttress this hypothesis.

Although cardiac involvement in sarcoidosis has been said to be rare by a few earlier publications, with increasing awareness more cases are being diagnosed. A patient with long standing history of proven sarcoidosis, recently treated for recurrent congestive heart failure and cardiac dysrhytmia was found to have a prolapsed mitral valve as well as an apical left ventricular aneurysm by both echocardiography and angiocardiography.

Case Presentation

A thirty-seven-year-old, black male, presented for the third time at the University of Chicago Hospitals with signs and symptoms of congestive cardiac failure in mid-May, 1974. Though he had had an erythematous skin rash in late 1957, he fared quite well until November, 1965, when he first received treatment here for what was presumed to be bacterial conjunctivitis of the left eye.

The following month he was admitted to the Cook County Hospital, with complaints of weight loss and moderate degree of shortness of breath on slight exertion. Chest X-ray demonstrated bilateral hilar adenopathy and the diagnosis of sarcoid was confirmed by mediastinal lymph node biopsy (Fig. 1). He took his Prednisone tablets only intermittently, managing to keep well until March, 1968, when he again required admission to the Cook County Hospital because of edema, shortness of breath and fever. Then, he was first informed of the presence of both a heart murmur and pulmonary congestion. Subacute bacterial endocarditis was also suspected, but not proven, and the patient was discharged after five weeks on Prednisone, digitalis and diuretic therapy.

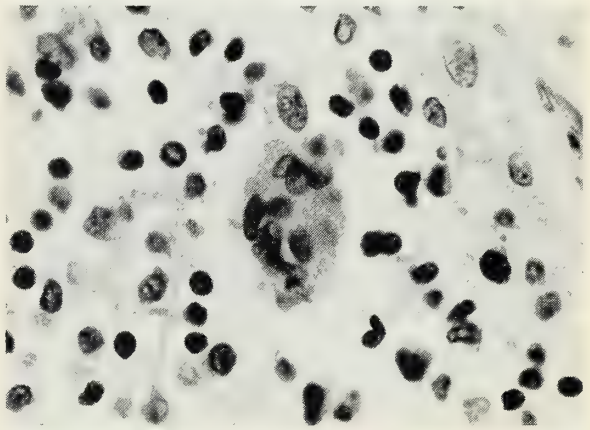
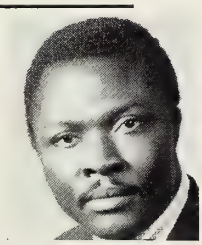


Figure 1. Patient's mediastinal lymph node biopsy specimen showing non-caseating granulomatous reaction. Staining for acid-fast bacilli was negative.

Second Admission

He again discontinued taking his medications in August, 1971, only to suffer a relapse with subsequent admission to the University of Chicago Hospitals in October, 1971. Physical examination revealed, in addition to signs of congestive cardiac failure, multiple small shotly, but mobile, non-tender anterior cervical lymph nodes, an atrial gallop, a normal first heart sound followed by a murmur of mitral regurgitation and a widely split second heart sound with a very loud pulmonic component. A ventricular gallop was also



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RAUL E. FALICOV, M.D., is an Associate Professor and Chief of Cardiovascular Hemodynamics Studies in the Department of Medicine at University of Chicago. He is a member of many organizations and has published numerous articles.

LEON RESNEKOV, M.D., is a Professor and Joint Director of the Cardiology Section as well as the Director of the Ischemic Heart Disease Project in the Department of Medicine at University of Chicago.

audible. Splenomegaly was confirmed by transmission-emission scan, while chest X-rays (Fig. 2 & 3) showed fine nodular interstitial infiltrates, bilateral hilar adenopathy, cardiomegaly and pulmonary congestion.



Figure 2.

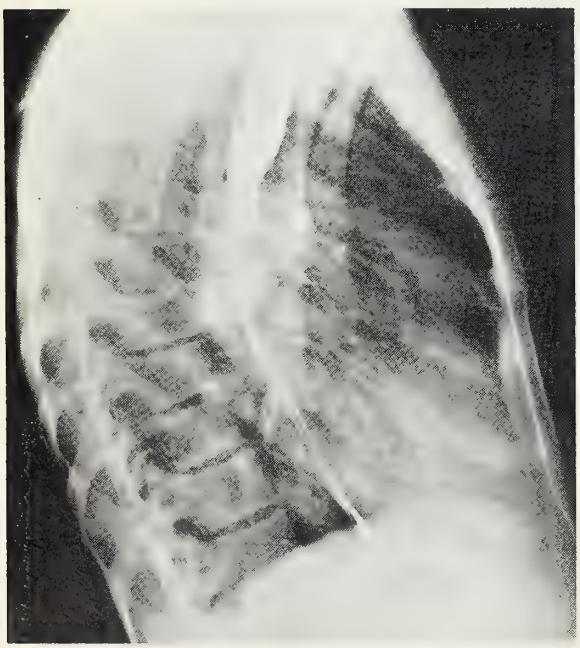


Figure 3

Figures 2 and 3: Patient's chest X-rays—Antero-posterior and left lateral views respectively—taken at the second admission to University of Chicago Hospitals in October, 1971. Bilateral hilar adenopathy appears quite prominent as well as cardiomegaly and moderate pulmonary congestion. Diffuse, fine, nodular, interstitial infiltrates are also demonstrated.

An E.C.G. (Fig. 4) demonstrated sinus tachycardia with occasional premature ventricular beats, bi-atrial hypertrophy and intra-ventricular

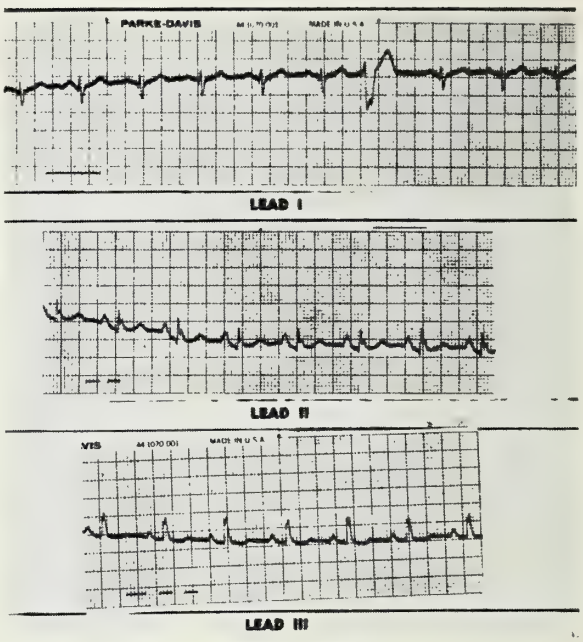


Figure 4A.

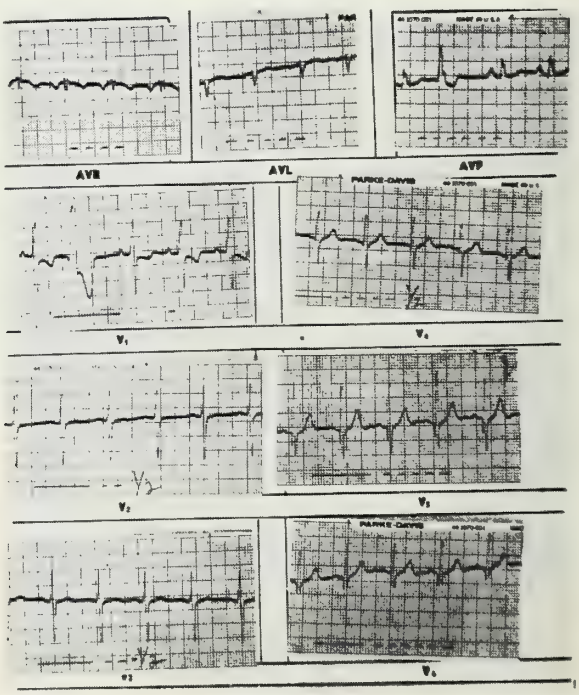


Figure 4B.

Figures 4a and 4b: 12-lead electrocardiogram of the same patient in November, 1971 showing a slight degree of tachycardia, possible biatrial enlargement, occasional premature ventricular beats and slight intra-ventricular conduction delay. Note the right axis deviation in the frontal plane.

conduction delay. The liver biopsy (Fig. 5) yielded areas of focal necrosis with non-caseating granulomas as well as hemosiderosis with non-specific reactive changes. Erythrocyte Sedimentation rate was 64 mm/hr by the Westergreen method, while skin tests for tuberculosis, histoplasmosis, coccidiomycosis, mumps and trichophytes were negative. Though serum calcium was 9.7 mg/100 ml with a phosphate level of 3.4 mg/100 ml, serum amylase was 225 units/ml and serum alkaline phosphatase was markedly elevated at 339 international units. The test for alkaline phosphatase iso-enzymes confirmed their liver origin.

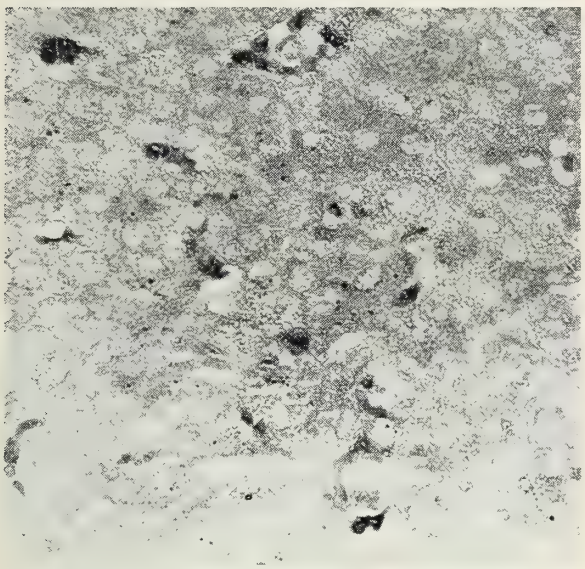


Figure 5. Patient's liver biopsy specimen depicting areas of focal necrosis with non-caseating granulomas as well as hemosiderosis and non-specific reactive changes. Again, staining for acid-fast bacilli was negative.

Further Findings

Pulmonary function studies (Fig. 6) showed severe restrictive abnormality with a vital capaci- of 1.96 liters. Fungal immuno-diffusion tests as well as the search for connective tissue disorders proved unrewarding and the bone marrow was normal. The patient responded very well to the combination therapy of Prednisone 45 mg daily; INH 300 mg daily; Digoxin 0.25 mg daily; and Furosemide 40 mg daily, with 50 milli-equivalents of Potassium Chloride supplement. Prior to discharge, his chest X-ray showed diminution in cardiac size and vital capacity increased to 2.7 liters.



Figure 6. Results of patient's pulmonary function studies in November, 1971. Note the severe restrictive abnormality. This improved moderately after treatment.

Relapse

He was subsequently lost to follow-up and presented in the emergency room in mid-May 1974 with yet another relapse of congestive cardiac failure. Auscultation again revealed a quadruple rhythm with a murmur of mitral regurgitation, as well as a mid-systolic click. The electrocardiogram demonstrated sinus tachycardia with infrequent premature ventricular beats and right axis deviation. Arterial PO_2 was 53, PCO_2 was 30 and pH was 7.41.

An echocardiogram (Fig. 7) depicted definite prolapse of the posterior mitral leaflet. This was confirmed by left ventriculography (Figs. 8 & 9). He also had an apical aneurysm. He again responded well to re-institution of his previous



Figure 7. Echocardiographic appearance of the patient's mitral valve showing posterior movement of the posterior leaflet of the mitral valve during systole.



Figure 8.

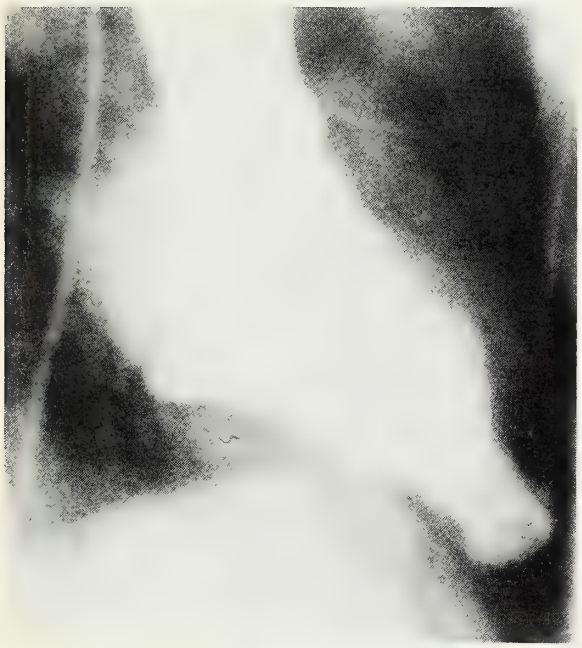


Figure 9.

Figures 8 and 9: End-diastolic and end-systolic frames of patient's left-ventriculography in the right anterior oblique projection. Both frames demonstrate diminished left ventricular contractility and an apical aneurysm while the prolapsed posterior mitral valve leaflet with mitral regurgitation is easily seen during systole.

medications, but has recently developed frequent premature ventricular beats (Fig. 10), requiring procainamide therapy for control.

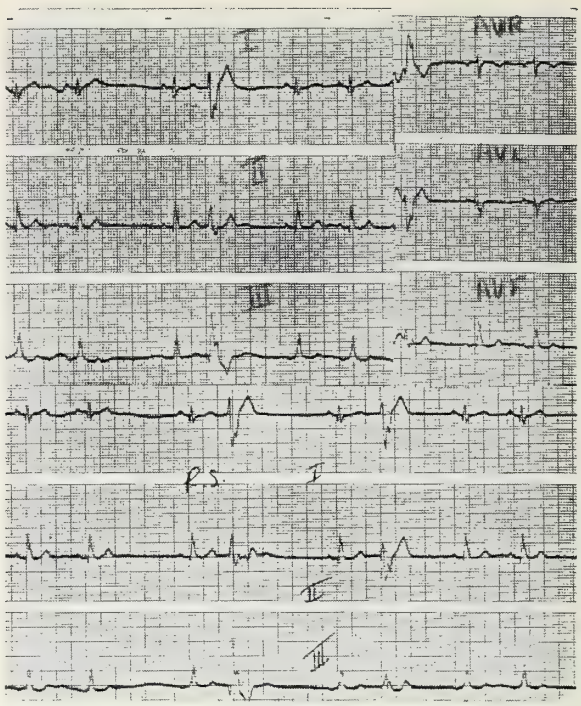


Figure 10A.

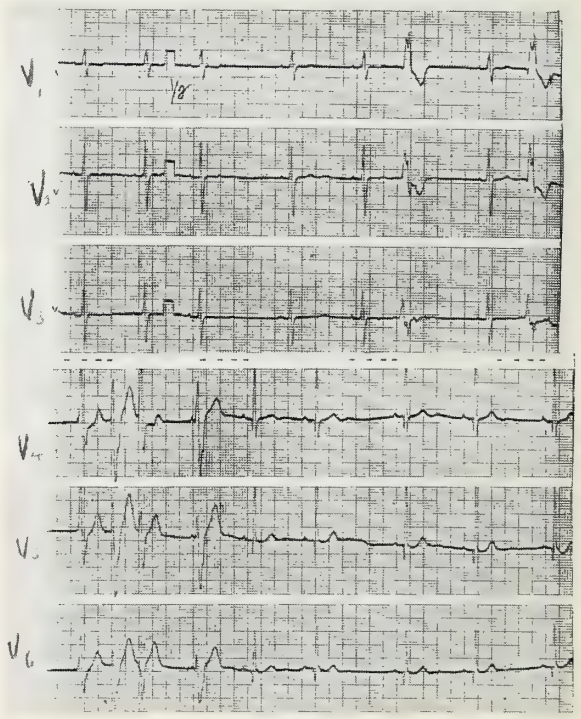


Figure 10B.

Figures 10a and 10b: Recent conventional electrocardiogram of this patient. Since the earlier tracings of November, 1971, ventricular premature beats have become more frequent. Tracings also depict rare episodes of sino-atrial pause.

Discussion

Since the first description of sarcoid lesions of the heart by Bernstein, Konzlemann and Sidlick[1] in 1929, cases of small numbers of patients have been reported. Also, subsequent to Gentzen's[2] first report in 1937 of myocardial sarcoidosis as the cause of death in one patient, other reports including that of Yesner[3] have appeared in the medical literature.[4-13] Goodwin, Oakley, and Raftery[14] in 1966 suggested that papillary muscle dysfunction might be secondary to infiltration of the heart by sarcoid. This opinion was further supported by Cohen and Roberts[15] in 1972. However, the syndrome of prolapsed mitral valve has not been previously reported in sarcoid heart disease.

Though it is difficult to pinpoint the exact onset of sarcoidosis in our patient, clinical history suggested the appearance of erythematous skin lesions about eight years prior to his first admission to the Cook County Hospital. Also, his earlier episode of conjunctivitis might have been caused by sarcoidosis. However, the murmur which was first documented in 1968 probably signified the onset of mitral valve disease.

Our understanding of the "hemodynamic consequences of the leaking mitral valve," has improved considerably since the astute observations by Wiggers[16] in 1922. In 1966, Barlow and Bosman[17] drew the world's attention to the existence of a "Billowing Mitral Valve Syndrome." Initially considered benign and probably limited to congenital disorders, particularly Marfan's Syndrome, prolapsed mitral valve is now being recognized with greater frequency in various diseases affecting the mitral valve apparatus, such as the infiltrative cardiomyopathies, connective tissue disorders and coronary artery disease. The echocardiographic appearance has been precisely demonstrated by Feigenbaum,[18] while the angiographic-morphologic correlations have lately been shown by Wigle and others.[19]

Hypothesis

Our hypothesis is that this thirty-seven-year-old, black male, developed posterior mitral valve leaflet prolapse because of sarcoid infiltration of the mitral valve apparatus. The recent appraisal of this apparatus by Perloff and Roberts[20] sheds further light on the various mechanisms involved. Fleming[21] a few months ago, reviewed fifty cases of sarcoid heart disease, twenty of which proved fatal and had necropsy confirmation.

It is recognized that prolapsed mitral valve, *per se,* hardly causes death, and the rhythm disturbances may be part of the underlying myocardial disease. Our patient also has an apical aneurysm of the left ventricle, most likely related to sarcoid infiltration. While the precise prognostic implications of prolapsed mitral valve continue to be unfolded, it is important to be aware of its existence in sarcoid heart disease. ◄

References

A complete bibliography for "Mitral Valve Prolapse in Sarcoid Heart Disease" may be obtained by writing the *Illinois Medical Journal,* 55 E. Monroe St., Suite 3510, Chicago 60603.

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Specialist and Generalists working together to make the Hartford area a better place to live and practice medicine. Thirteen physicians presently serve the area in two clinics and also solo practice—there is a need for more physicians to serve this fast growing area—specifically in Family Practice and Internal Medicine. A new hospital building has been completed and will provide the best facilities possible. The service area population is over 30,000, while Hartford is a community of 7,000 and part of the metropolitan Milwaukee Planning Area, less than 30 minutes away from major cultural, educational and social resources. Hartford and its outlying communities offer more of a rural community flavor with proximity to lakes, ski hills and other recreational advantages. This invitation to Hartford, Wisconson is the co-operative effort of the physicians, clinics, hospital and interested community leaders. Contact the Hartford Community Physician Research Committee by letter or phone, through N. K. Reynolds, at Hartford Memorial Hospital, 1032 E. Sumner, Hartford, Wisconsin 53027, (414) 673-2300.

Obituaries

****Bondurant, Flint**, Cairo, died Aug. 19, at the age of 89. He graduated from Northwestern in 1909. Dr. Bondurant practiced medicine for over 50 years.

***Blomberg, Thorsten**, Rockford, died September 16, at the age of 75. He graduated from Rush Medical School in 1927.

Burger, Louis, Springfield, died March 20 at the age of 43.

***Crown, Edward**, Chicago, died Sept. 30, at the age of 70. He graduated from Stritch Medical School in 1930.

Ekonomou, Alexander, Peoria, passed away April 12 at the age of 85.

****Feldman, Louis**, Chicago, died Sept. 12, at the age of 83. He graduated from Stritch Loyola University in 1922. Dr. Feldman had practiced medicine for over 50 years.

***Hall, Russell**, Hinsdale, passed away Sept. 15. He graduated from University of Illinois in 1956.

Josephson, Harry, longtime employee of ISMS, died October 21. Many members of the society will remember him as the man who brought around the Delegate's Handbooks at the Annual Meeting caucuses. An accomplished musician, he played violin and viola with many symphony orchestras from Cleveland to Dubuque. His published works have been performed throughout the U.S. We will miss Harry's jovial personality around the ISMS office.

***Lang, Samuel**, Evanston, died Sept. 14, at the age of 69. He graduated from Northwestern in 1926.

Lynn, Lawrence, Chicago, died March 21, at the age of 68. Dr. Lynn graduated from Stritch School in 1933.

***Moe, Arnold**, East St. Louis, died June 9 at the age of 66. Dr. Moe graduated from University of Minnesota in 1940. He was a past president of the Illinois Heart Association.

***Moore, Eugene**, Collinsville, passed away at the age of 75.

***Nicholson, Paul**, died July 31, at the age of 82. Dr. Nicholson graduated from Chicago Medical in 1927.

O'Sullivan, George, St. Louis, died Sept. 28 at the age of 71. He graduated from St. Louis University in 1927.

****Roos, Edmund**, Decatur, died Aug. 17, at the age of 83. He graduated from Rush in 1916. Dr. Roos was past president of Macon County Medical Society. Dr. Roos also practiced medicine for over 50 years.

***Sheehan, Fred**, Evergreen Park, died Sept. 16, at the age of 77. He graduated from Northwestern in 1929.

***Walker, John**, died Sept. 28 at the age of 67. He graduated from Chicago Medical in 1936.

Webb, Mark, Texas, passed away Aug. 28, at the age of 68.

***Wiltracks, George**, St. Charles, died October 1, at the age of 70. Dr. Wiltracks graduated from University of Illinois in 1929. He was former deputy director of the Illinois Department of Public Welfare and also past president of the Kane County Medical Society.

***Youngerman, William**, Champaign, died October 8 at the age of 68. He graduated from the University of Cincinnati in 1932.

**Indicates ISMS member*
***Indicates ISMS member and member of the Fifty Year Club*

Housestaff News

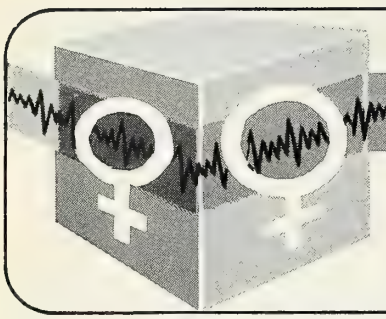
(Continued from page 534)

of instruction. This works out to $7.50 an hour. If a resident were to be involved in a training program in which 100% of his time were spent in educational activities, with no patient-care responsibility, then it would be fair to charge him $600 a week for his 80 hours of instruction, or $29,400 a year (less vacation). Thus, depending on the amount of educational or service content of a residency, a fair salary for a resident could be as much as $58,800 or as little as the resident *owing* the hospital $29,400 a year. There are probably few, if any programs that are 100% service or 100% education.

Applying these same figures to the more typical residency, some rather interesting figures are obtained. Consider the resident who spends half his 80 hour week involved in patient care service. If he were to be paid for these services, and charged for his educational activities, he should receive $14,700 per year, a figure not far from current figures in large urban hospitals. If two-thirds of his time is spent on patient care services and only one-third on education, he should receive $600 per week or $29,400 per year. The resident who spends one-third of his time on patient-care and two-thirds on education should receive nothing since the charges for his education exactly balance the salary for his service.

Without question, this approach is simplistic and requires many assumptions that may not be correct in any given program. However, these figures are not presented as suggested salaries, rather an example of the differences of opinion and the perspectives that lead to these differences. Hospital administrators are understandably less than enthusiastic about paying residents large salaries when the bulk of their time is spent in educational and not service activities. Housestaff who spend the bulk of their time in patient care service are likewise understandably dissatisfied with what they consider to be less than even minimum wage salaries for their services.

Because of the difficulty in determining exactly what consitutes the educational part and what constitutes the service part of a residency, these differences are likely to persist. As a reasonable alternative to hostilities, both sides should be more receptive to the perspective of alternative points of view, and with this perspective and quiet discussion, differences may better be solved.



pulse... of the doctor's wife

MRS. HAROLD KEEGAN, Editor

Viet Refugee Assisted by Medical Auxiliary

"Chuck", as Ly Tu Chac has been nicknamed, arrived in Quincy, Illinois, on August 14. This was the end of a long journey that started with the last 'copter out of Tan Son Nhut Air Base in Saigon. The helicopter took him to a ship waiting off shore, then on the Subic Bay in the Philippines. Next a plane to Guam. After two weeks there, he boarded a Boeing 747 and in 28 hours was at Fort Chaffee.

During his three months at the relocation center, not knowing where he might go, "Chuck" was cheered by the news his good friends, Mr. and Mrs. Tran Duy Thack, Quincy's first Vietnamese refugees, Mrs. delCastillo, and the rest of the Medical Auxiliary were working quietly to get him to Quincy.

"Chuck" is alone in Quincy, living in an apartment. His sponsors have paid the initial three months rent. The other members of his family were unable to leave Saigon. "Chuck" is employed as a warehouse maintenance man for Sears. He speaks five languages and is a former U.S. government employe.

The Adams County Medical Auxiliary under the direction of Mrs. Shelby G. Gamble, *President,* Mrs. Leonard Grayson, wife of the Adams County Medical Society President, Mrs. Julio C. delCastillo, the Auxiliary's principal negotiator and Mrs. Ralph W. Theobald, *Publicity Chairman,* helped in settling this Vietnamese refugee.



Welcome for "Chuck"

Adams Co. Medical Auxiliary women join Sears Roebuck manager Don McCorry in official welcome to Ly Tu Chac, 30 year old Vietnamese refugee, who became a productive part of the Quincy Community a month ago.

Left to right: Don McCorry, Mrs. Leonard Grayson, Mrs. Shelby Gamble, Mrs. Ralph Theobald, Chac and Mrs. Julio delCastillo.

Adams County Med. Aux. sponsored a Centennial Ball to benefit the Blessing Hospital School of Nursing.

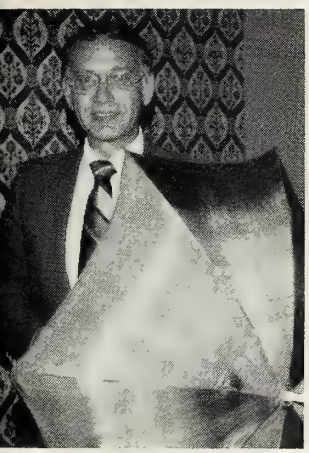
Fall Conference

The Fall Patchwork Conference, September 25, in Springfield, Illinois, was attended by 100 auxiliary members. Twenty-three county Auxiliaries were represented—the largest delegations were as follows:

5 Kane	9 Sangamon
5 Madison	7 Stephenson
10 Peoria	7 Will-Grundy
10 St. Clair	



Freeman-Hughes Home—Pouring is Mrs. Hershel Fulcher, President, Sangamon County.



Dr. S. Burris performing magic at the Board Dinner.



Jean Wochos and victim—Demonstration of the "Heimlick Maneuver" for treatment of food choking.

Five doctors' wives from Fulton County attended as observers. It is hoped this will result in the organization of an auxiliary in that county. Those in attendance included were Mrs. Robert Ridley, Mrs. Everett Coleman, Mrs. Marvin Schmidt, Mrs. E. Salomone and Mrs. J. K. Welch.



"COUNTY STORE"—Mrs. Donald Mitzelfelt, Tazewell County and Mrs. Arnold Claycomb, District 5 Councilor.

The Philippine Medical Association Auxiliary was also represented. The Auxiliary is considering joining our Auxiliary. Attending the conference were:

Geline Tanquilut, R.N., *President*
Farida Chua, M.D., *Vice-President*
Dionnie Battung, M.D., *Board of Governors*
Nat Pepa, *Chairman of Social Committee*
Charito Florendo, M.D., *Board of Governors*
Lucy Lariosa, *Board of Governors*
Dely Villalon, *Board of Governors*
Profita Ilagan, *Immediate Past-President*
Ruth Paras, guest



Freeman-Hughes Home—Mrs. Paul David, ISMS Aux. Director and Director of Fall Conference, Mrs. Eugene Vickey, ISMS Aux. President, and Dr. Floyd Barringer, Host and owner of the home.

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

AURORA—Board eligible or certified gynecologist to join established corporation in town of 75,000—30 miles west of Chicago. Guaranteed salary 1st year with partnership arrangements thereafter. Option to buy in anytime. G. J. Shimkus, M.D., 143 So. Lincoln Ave., Aurora, 60505. 312-896-7892, (5)

CHICAGO: Take over large general practice. No investment required. Modern, fully equipped and staffed facility. Salary and Profit Sharing yields. Contact: M. Beederman, 2400 E. Devon, Des Plaines 60018. 312-298-3500 (2)

CHICAGO: Medical Center N.W. Side of Chicago with clinical laboratory, X-rays, physical therapy. 2 Family Physicians, members A.A.P.F., looking for a young, well trained, ambitious F.P. Privileges in hospital with Department of Family Practice, F. S. Steinitz, M.D., 3653 W. Lawrence, Chgo. 60625 (312-478-6000). (12)

CHICAGO: Physician needed for well established, ultra modern medical center. Full laboratory and X-ray. Congenial working conditions and excellent co-workers. Good hospital associations. No evenings or weekends. Clinic located south side, near lake. Contact Mr. Lawrence, Booker Family Health Care Center, 747 E. 47th, Chicago, 60653, (312) 624-4800. (1)

DIXON: Internist-Pediatrician-Orthopedic Surgeon-board certified/board eligible. Well established multi-specialty clinic, closely affiliated with a 200 bed hospital, offers opportunities to build a large practice in these specialties. Progressive community, within ninety miles of Chicago, offers a unique family oriented environment. No traffic problems, clean air, and excellent recreation areas combine to provide the "good life." Only 45 minutes from Rockford, allows easy access and exposure to academic medicine. Phone collect—John Tatum, Administrator, Medical Arts Clinic, Dixon, 61021. (815) 288-5531. (3)

HARDIN: Doctor wanted to work in modern three doctor medical center presently staffed with one doctor. Laboratory and x-ray equipment available. New ambulance which is manned by 50 trained EMTA volunteers. Hospital nearby. Located in beautiful Calhoun County Illinois between the Mississippi and Illinois rivers within one hour drive of St. Louis. Excellent hunting and fishing facilities. Contact: Calhoun County Farm Bureau, Hardin, Illinois 62047. Phone 618-576-2233. (3)

HARVEY: Pleasant moderate-sized general practice with full lab, expert clerical staff and list of consultants in Chicago south suburbs with modern hospital nearby. Full or part-time M.D.'s desired. Competitive salary negotiable, with benefits, flexible schedule and other valuable considerations, as office is expanding. Good opportunity for right doctors. Contact: Mrs. Wynne, 14734 Oakley, Harvey, (312) 331-8000 (3)

KANKAKEE: Emergency Room Physician, Board eligible or certified preferred, needed for 300 bed acute care hospital in Chicago area. Liberal fringe benefits. Contact Raymond Malott, M.D., St. Mary's Hospital, 500 West Court Street, Kankakee 60901. Phone (815) 939-4111. (3)

McHENRY: Immediate openings for General Internist, Cardiologist, Cardio-Vascular and Thoracic Surgeon, Urologist and Orthopedic Surgeon. Outstanding opportunity to join multi-specialty group in mid-west resort area near Chicago. Salary with incentive from day one: fringe benefits and unusually good income potential. Group building directly connected to 143 bed community hospital. Contact: Ted L. Rolander, M.D., McHenry Medical Group, 1110 N. Green St., McHenry, 60050 or (815-385-1050) (3)

NAPERVILLE: Emergency Department Physicians wanted full time! For busy E.R. in a 154-bed growing hospital located in beautiful residential suburb 40 miles west of Chicago. Career-service oriented. ACEP membership preferred. All shifts to rotate. Full back-up coverage. Excellent fringe benefits package. Spacious new Emergency Department with EMS and MICU programs developing! Volume about 20,000 patient visits annually. Curriculum vitae and salary requirements first letter. Contact Dr. A. Albrecht, E.R. Director, Edward Hospital, Naperville, 60540, or call (312) 355-0450.

NASHVILLE: Population 3,000—serving area 14,000 plus. Board certified or eligible General Surgeon willing to do general practice, Solo or Associate. 72 bed JCAH Hospital. 50 miles east of St. Louis, Mo. Contact: T. K. Janssen 618-327-8236, 603 S. Grand, Nashville 62263. (3)

VANDALIA: Population 6,000. Family physicians needed. Office space available. Hospital with 100 beds, all services. An excellent school system and all denominations of churches. One hour from St. Louis on the interstate highway. Local lake for boating and fishing, close to the Carlyle Lake. Recreational facilities. Contact: D. H. Rames, M.D., 1029 N. 8th St., Vandalia, 62471 (618-283-3012) or Larry Harrison, Administrator, Fayette County Hospital, Vandalia, 62471 (618-283-1231). (12)

WEST DUNDEE: Small town—45 miles NW from Chicago by Tollroad—Active, well established Family Practice—Large drawing area—Only 1 other physician in town—2 large modern hospitals nearby—Office, equipment and residence available (Rental, sale or financing) —Martin C. Koenig, M.D., 118 N. 3rd, West Dundee 60118. Call (312) 428-6725 or 426-2600 (12)

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LOYOLA UNIVERSITY-HINES VA HOSPITAL BOARD REVIEW COURSE IN INTERNAL MEDICINE

January 6—May 18, 1976

Every Tuesday night from January 6, 1976 through May 18, 1976, from 6:30 p.m. to 9:30 p.m., a preparatory course will be given for the American Board of Internal Medicine at Loyola-Hines Medical Center. The course will be sponsored by the L.U. Stritch School of Medicine and Hines VA Hospital. There will be 20 sessions given by highly qualified authorities in their respective fields.

Jan. 6, 1976	RHEUMATOLOGY
Jan. 13, 1976	IMMUNOLOGY
Jan. 20, 1976	CARDIOLOGY
Jan. 27, 1976	CARDIOLOGY
Feb. 3, 1976	CARDIOLOGY
Feb. 10, 1976	HEMATOLOGY
Feb. 17, 1976	HEMATOLOGY
Feb. 24, 1976	ENDOCRINOLOGY
March 2, 1976	ENDOCRINOLOGY
March 9, 1976	GASTROENTEROLOGY
March 16, 1976	GASTROENTEROLOGY
March 23, 1976	PULMONARY
March 30, 1976	PULMONARY
April 6, 1976	RENAL
April 13, 1976	RENAL
April 20, 1976	NEUROLOGY
April 27, 1976	NEUROLOGY
May 4, 1976	ONCOLOGY
May 11, 1976	INFECTIOUS DISEASE
May 18, 1976	INFECTIOUS DISEASE

The fee for the course will be $200.00 (Residents $50.00) payable in advance. Please make all checks payable to: Loyola University Stritch School of Medicine #1000-24-R.

Name

Address

Send checks and inquiries to: **John G. Demakis, M. D.; Assistant Chief of Medical Services; Hines VA Hospital; Rm. 1492; Hines, Ill. 60141.**

ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110

Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

December, 1975

Antibiotics

UPDATE ON ANTIBIOTICS
For: Pediatricians. Monthly lecture/dinner program. Dec. 16, 8:00 PM. Downtown Holiday Inn, Chicago. **Speaker:** Dr. Pierce Gardner. **Sponsor, contact:** Chicago Pediatric Society, 2800 W. 87th St., Chicago, IL 60652. Att'n: Thomas P. Driscoll.

Cardiology

FIRST ANNUAL SYMPOSIUM ON CARDIOLOGY
For: All Physicians. Symposium. Dec. 10. Chicago. **CME Credit:** 3 hrs. AMA Cat. 1; AAFP. **Fee:** None. **Sponsor, contact:** Martha Washington Hospital, 4055 N. Western Ave., Chgo. 60618. Att'n: Ralph Gradman, M.D.

Endocrinology

AMENORREA: CAUSES AND TREATMENT
For: All MDs. Lecture. **Speaker:** Robert L. Rosenfeld, MD, Assoc. Prof. of Pediatrics, Univ. of Chicago. Dec. 2. Highland Park, Ill. **Fee:** None. **Sponsor, Contact:** Highland Park Hospital, 718 Glenview Ave., Highland Park, Ill. 60035. Attention: Mrs. Susan Stuttle.

Family Medicine

COMPLICATIONS OF THE PILL AND IUD
For: All physicians. Group Discussion and Lecture. Dec. 3-4. Dec. 3: 10 AM, Thorek Medical Center; 6:00 PM, Lincolnwood Hyatt House; Dec. 4: 10 AM, Bethesda Hospital. **Speaker:** Dr. Carolyn B. Coulam, Mayo Clinic. **CME Credit:** 5 Hrs. AMA Category 1. **Fee:** $10 (other than Staff for dinner). **Reg. Deadline:** Nov. 29 (dinner only). **Sponsor:** FAB³/CME. **Contact:** Thorek Medical Center, 850 W. Irving Park Road, Chicago, IL 60613. Att'n: Mr. Peter Pierdinock.

ACUTE CARDIAC CARE
For: All MDs. 3-Day Course. Dec. 3-5. Chicago. **CME Credit:** 21 hrs. AMA Cat. 1. **Fee:** $125. **Reg. Limit:** 80. **Sponsor, Contact:** Cook County Grad. School of Med., 707 S. Wood St., Chicago, Ill. 60612.

BASIC OBSTETRICS
For: All MDs. 5-Day Course. Dec. 1-5. Chicago. **CME Credit:** 35 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 50. **Sponsor, Contact:** Cook County Grad. School of Med., 707 S. Wood St., Chicago, Ill. 60612.

PULMONARY PHYSIOLOGY AS APPLIED TO CLINICAL PRACTICE
For: Physicians. Lecture. **Speaker:** Kyung W. Koo, M.D., Sherman Hospital, Dec. 9, 8:00 PM, Elgin. **CME Credit:** 2 hrs. AMA Cat. 1. **Fee:** None. **Sponsor, contact:** CME Committee of Sherman Hospital, 934 Center St., Elgin, IL 60120. Mrs. Mary Anne Stiegemeier, Sec.

General Medicine

INTENSIVE CORONARY CARE
For: Physicians, Nurses, Paramedics. Seminar. **Speaker:** Dr. J. P. Stokes, Mayo Clinic. Dec. 2. Elmhurst, Ill. **CME Credit:** 1 hr. AMA Cat. 1. **Fee:** None. **Sponsor, Contact:** Memorial Hospital of DuPage County, Avon & Schiller, Elmhurst, Ill. 60126. John H. Huss, MD, Director of Medical Education.

GASTROINTESTINAL EMERGENCIES—SURGICAL AND MEDICAL
For: All MDs. Symposium. Dec. 4. Richmond, Indiana. **CME Credit:** 6 hrs. AMA Cat. 1. **Fee:** $35. **Sponsor, Contact:** Indiana Univ. School of Med., Div. of CME, 1100 W. Michigan St., Indianapolis, Ind. 46202. John Roscoe, Assistant Director.

Hypertension and Renal Disease

FLUID & ELECTROLYTE BALANCE, HYPERTENSION, AND RENAL DISEASE
For: Internists and General Practitioner. 5-day postgraduate course. Dec. 8-12. Passavant Pavillion, Northwestern Mem. Hosp., Chicago. **CME Credit:** AMA Cat. 1. **Fee:** $70-140. **Reg. Limit:** 110. **Sponsor, contact:** Amer. Colleges of Physicians & Northwestern U. Med. School Registrar, Postgraduate Courses, 4200 Pine St., Philadelphia, PA 19104.

Internal Medicine

ADVANCES IN THE DIAGNOSIS AND MANAGEMENT OF HYPERTENSION
For: All MDs. Lecture. **Speaker:** Suzanne Oparil, MD, Assoc. Prof. Dept. of Med. Dec. 10. Chicago. **CME Credit:** 3 hrs. AMA Cat. 1; AAFP Elective. **Fee:** $20. **Sponsor, Contact:** Univ. of Chicago, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago, Ill. 60637. Attention: Mrs. Elaine Ehrman.

Medicine and Rheumatology

RHEUMATIC DISEASE: MANAGEMENT OPTIONS
For: GPs, FPs, Internal Medicine. Symposium. **Speaker:** Ronald Saykaly, M.D., Dec. 19-20, 8:00 AM-5:00 PM. Lexington, KY. **CME Credit:** 9 hrs. AAFP Prescribed. **Fee:** $75.00. **Sponsor, contact:** University of Kentucky, Cont. Educ. College of Med., Lexington, KY 40506. Attn: Frank R. Lemon, M.D.

Orthopedics

ORTHOPEDIC PROBLEMS OF THE NEWBORN
For: Pediatricians. Monthly lecture (dinner meeting). Dec. 16, 1975. Downtown Holiday Inn, Chicago. **Speaker:** Dr. Jack Davis. **Sponsor, contact:** Chicago Pediatric Society, 121 W. 154th St., Harvey, IL 60426. Att'n: Lowell M. Zollar, M.D.

Pediatrics

CURRENT PEDIATRIC MANAGEMENT
For: Ped, FP, GPs. Symposium. Dec. 3. Indianapolis. **CME Credit:** 6 hrs. AMA Cat. 1. **Fee:** $35. **Sponsor, Contact:** Indiana Univ. School of Med., Div. of CME, 1100 W. Michigan St., Indianapolis, Ind. 46202. John Roscoe, Assistant Director.

Psychiatry

THE PRIVATE SECTOR OF MENTAL HEALTH SERVICES PRESENT AND FUTURE
For: Psychiatrists. Lecture. **Speaker:** Jacob Fishman, MD, Pres. of American Health Services, Inc. Dec. 17. Chicago. **Fee:** None. **Sponsor, Contact:** Institute of Psychiatry, Northwestern Med. School, 320 E. Huron St., Chicago, Ill. 60611. Attention: Dr Barbara A. Kay.

Psychotherapy

THE RATIONAL-EMOTIVE APPROACH TO THERAPY
For: Mental Health Treatment Professionals. Symposium. Dec. 17, 1:00-4:00 PM, Forest Park. **Speaker:** Albert Ellis, Ph.D. **Fee:** $10. **Reg. Limit:** 204. **Reg. Deadline:** Reservations Req. **Sponsor, Contact:** Riveredge Hospital Foundation, 8311 W. Roosevelt Road, Forest Park, IL 60130. Att'n: John Pontarelli.

Surgery

HAND SURGERY—THE STATE OF THE ART
For: Orthopedic Surg.; Surgical Residents; Industrial Surg. Three-Day Course. Dr. Robert R. Schenck, Course Chairman. Dec. 4-6. Chicago. **CME Credit:** 16 hrs. AMA Cat. 2; AAFP Elective. **Fee:** $200. $100 (Residents). **Co-Sponsors:** Rush-Presbyterian St. Luke's Medical Center and American Society for Surgery of the Hand. **Contact:** Robert R. Schenck, MD, 1725 W. Harrison St., Suite 33, Chicago, Ill. 60612.

SPECIALTY REVIEW COURSE IN GENERAL SURGERY, PART II
For: Surgeons. 11-Day Course. Dec. 1-12. Chicago. **CME Credit:** 99 hrs. AMA Cat. 1. **Fee:** $400. **Reg. Limit:** 150. **Sponsor, Contact:** Cook County Grad. School of Med., 707 S. Wood St., Chicago, Ill. 60612.

RECENT ADVANCES IN OCULAR SURGERY
For: All Physicians. Lecture. Dec. 17. Chicago. **CME Credit:** 1 hr. AMA Cat. 1, AAFP. **Fee:** None. **Sponsor, contact:** Martha Washington Hosp., 4055 N. Western Ave., Chgo. 60618. Attn: Ralph Gradman, M.D.

Surgery and Medicine

INTERIM SEMINAR ON SURGERY AND MEDICINE FOR LAKE COUNTY
For: Medical Professionals. Lecture. Dec. 3, 9:00 AM-11:00 AM. Waukegan. **CME Credit:** 2 hrs. AMA Cat. 1. **Fee:** None. **Reg. Deadline:** Dec. 1. **Sponsor, contact:** St. Therese Hospital, 2615 W. Washington, Waukegan, IL 60085. Attn: R. M. Adelman, D.D.S., M.D.

Urology

SPECIALTY REVIEW COURSE IN UROLOGIC PATHOLOGY & X-RAY
For: Urologists. 2½ Day Course. Dec. 4-6. Chicago. **CME Credit:** 20 hrs. AMA Cat. 1. **Fee:** $100. **Reg. Limit:** 75. **Sponsor, Contact:** Cook County Grad. School of Med., 707 S. Wood St., Chicago, Ill. 60612.

January, 1976

Chest Diseases

MANAGEMENT OF TUBERCULOSIS IN GENERAL HOSPITALS
For: All specialties. Symposium. **Speaker:** Thomas J. Pozen, M.D., Director, DuPage County TB Clinic. Jan. 21, 2:00 PM-5:00 PM. Elmhurst Country Club, Wood Dale. **CME Credit:** 3 hrs. AMA Cat. 1, AAFP Elective. **Sponsor, contact:** DuPage County Medical Society, 646 Roosevelt Rd., Glen Ellyn, IL 60137.

Electrocardiographic Diagnosis

ELECTROCARDIOGRAPHIC DIAGNOSIS
For: General Practitioners. Internists. Lecture. Workshop. Jan. 13-15, 8:00 AM-5:00 PM. Ann Arbor, MI. **CME Credit:** AMA Cat. 1, AAFP Elective. **Sponsor, contact:** Robert K. Richards. Director, Office of Intramural Educ., Dept. of Postgrad. Med. & Health Professions Ed., Towsley Cntr., Univ. of Mich., Ann Arbor, MI 48104.

Endocrinology

FUNCTIONING AND NON-FUNCTIONING TUMORS OF THE PITUITARY
For: All physicians. Lecture. Jan. 20, 1976, 8:00 PM. Highland Park Hospital. **Speaker:** Raymond V. Randall, M.D., Mayo Clinic. **Reg. Limit:** 70. **Reg. Deadline:** Jan. 15. **Sponsor, contact:** Highland Park Hospital, 718 Glenview Ave., Highland Park, IL 60035. Att'n: Mrs. Susan Struttle, Admin. Secy.

Family Medicine

IMMUNOLOGY IN CLINICAL PRACTICE
For: Physicians. Lecture. Jan. 20. 8:00 PM. Sherman Hosp. **Speaker:** John Robinson, M.D., Loyola Medical Center. **CME Credit:** 2 hrs. AMA Cat. 1. **Fee:** None. **Sponsor, contact:** CME Committee of Sherman Hospital, 934 Center St., Elgin, IL 60120. Attn: Walter E. Gasser, M.D., Chairman.

General Surgery Trauma

CLINICAL HOSPITAL PROGRAM ON GENERAL SURGERY TRAUMA
For: All Physicians, Residents, Interns. 2-hour Evening Clinical Program. Jan. 20. Resurrection Hospital, Chgo. **CME Credit:** 2 hrs. AMA Cat. 1; AAFP. **Sponsor, contact:** Chicago Committee on Trauma of the Amer. College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. Attn: Mrs. Lillian Husa, Exec. Sec.

Orthopedics

FOOT PROBLEMS OF THE NEWBORN
For: Pediatricians. Monthly dinner meeting/lecture. Jan. 20. 8:00 PM. Holiday Inn, Chgo. **Sponsor, contact:** Chicago Pediatric Society, 2800 W. 87th St., Chicago, IL 60652. Attn: Thomas Driscoll, M.D. (for dinner reservations).

Psychiatry

EMPTINESS IN THE LIVES OF COMEDIANS
For: Physicians, Mental Health Professionals. Lecture. Jan. 7. 7:30-9:30 PM. Des Plaines. **Speaker:** Samuel S. Janus, Ph.D., NY Medical College. **CME Credit:** 2 Hrs. AMA Cat. 1, AAFP Elective. **Fee:** $15 (ind. lectures). **Reg. Limit:** 120. **Co-sponsors:** Chicago Medical School, Dept. of Psychiatry and Forest Hospital Foundation. **Contact:** Forest Hospital, 555 Wilson Lane, Des Plaines, IL 60016.

THE KEY CONFERENCE AND THE FUTURE OF THE AMERICAN PSYCHIATRIC ASSOCIATION
For: Psychiatrists. Lecture. Jan. 21. 8:00 PM. Passavant Hosp., Chicago. **Speaker:** Melvin Sabsin, M.D., American Psychiatric Association. **CME Credit:** 1½ Hrs. AMA Cat. 1. **Sponsor, contact:** Institute of Psychiatry, Northwestern U. Med. School, 320 E. Huron St., Chicago 60611.

MEDICINE FOR TODAY—Winter Sessions

For: **Practicing physicians in all specialties. IAFP's 26th Annual Lecture Series, with A-V and Q&A supplement. Emphasis on Family Practice, Gynecology, Gastroenterology, Electrolytes & Cardiology.** ***CME Credit:*** **30 hrs. (maximum, for Fall & Spring sessions) AAFP Prescribed, AMA Category 1.** ***Fee:*** **$100 AAFP mbrs., $110 non-mbrs. Meets in these cities on dates noted:**

***Belleville*—Dec. 4, Feb. 12, 19, 26, March 4, 11, 18.**
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***Beverly*—Feb. 11, 18, 25, March 3, 10, 17.**
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***Champaign*—Feb. 12, 26, March 11.**
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***Hinsdale*—Feb. 4, 18, March 3.**
***Kankakee*—Dec. 2, Feb. 10, 17, 24, March 3, 9, 16.**
***Park Ridge*—Feb. 11, 18, 25, March 3, 10, 17.**
***Peoria*—Feb. 19, March 4, 18.**
***Rockford*—Dec. 4, Feb. 12, 19, 26, March 4, 11, 18.**
***Rock Island*—Feb. 12, 26, March 11.**
***Springfield*—Feb. 19, March 4.**

Psychotherapy

THE RATIONAL THERAPY APPROACH TO CRISIS COUNSELING IN MEDICAL OR LEGAL SETTINGS
For: Mental Health Treatment Professionals. Symposium. Jan. 21. 1:00-4:00 PM. Riveredge Hospital, Forest Park. **Speaker,** Virginia Anne Church, J.D., Ph.D., Dean, Lewis Univ. College of Law. **Fee:** $10.00. **Reg. Limit:** 204. **Reg. Deadline:** Reservations Req. **Sponsor, contact:** Riveredge Hospital Foundation, 8311 W. Roosevelt Rd., Forest Park, IL 60130. Attn: John Pontarelli, Community Relations Coordinator.

Surgery

FIBEROPTIC ESOPHAGOGASTRIC ENDOSCOPY
For: All physicians. 3-day Course. Jan. 26-28. Chicago. **CME Credit:** 19½ Hrs. AMA Cat. 1. **Fee:** $250. **Reg. Limit:** 10. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612.

February, 1976

Chest Disease

LUNG CANCER
For: All MDs. Lecture. Feb. 11. 2:00-5:00 PM, Univ. of Chicago Hosp. & Clinics. **Speaker:** Nicholas J. Gross, MD., Ph.D., Asst. Prof. Dept of Med. **CME Credit:** 3 hrs. AMA Cat. 1; AAFP Elective. **Fee:** $20. **Reg. Limit:** 250. **Sponsor, contact:** Univ. of Chicago, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago, IL 60637.

SPECIALTY REVIEW COURSE IN THORACIC SURGERY
For: Thoracic Surgeons. 5-day course. Feb. 23-27. **CME Credit:** 40 hrs. AMA Cat. 1. **Reg. Limit:** 200. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612.

Emergency Medicine

EMERGENCY MEDICINE
For: Emergency Physicians. Lectures, panels, workshops. Feb. 23-27. 8:00-5:00 PM. Ann Arbor, MI. **CME Credit:** AMA Cat. 1; AAFP; ACEP. **Sponsor, contact:** Robert K. Richards, Director, Office of Intramural Educ., G1109 Towsley Center, U of Michigan, Ann Arbor, MI 48104. **Co-sponsor:** Michigan Chapter-Amer. College of Emergency Physicians.

Family Medicine

CHEMOTHERAPY IN COLON CANCER
For: Physicians. Lecture. Feb. 17. 8:00 PM. Sherman Hosp., Elgin. **Speaker:** Allan J. Schutt, M.D., Mayo Clinic. **CME Credit:** 2 hrs. AMA Cat. 1. **Sponsor, contact:** CME Committee of Sherman Hospital, 934 Center St., Elgin, IL 60120. Attn: Walter E. Gasser, M.D., Chairman.

Medical Audit

PAS INSTITUTE
For: MDs, Hospital Administrators, Health Record Analysts, Chiefs of Medical Records. 1-Day Institute. **Speaker:** Virgil N. Slee, M.D., Pres. CPHA. Ann Arbor, MI. **CME Credit:** 6 hrs. AMA Cat. 1; AAFP Elective; AOA Cat 2-0; ACGOPMS-Class 2. **Fee:** $65. **Sponsor, contact:** Commission on Professional and Hospital Activities, 1968 Green Rd., Ann Arbor, MI.

Medicine

FIFTH ANNUAL FRED H. PRIEBE MEMORIAL SYMPOSIUM ON ARTHRITIS
For: All MDs. Symposium. Feb. 11. Indianapolis. **CME Credit:** 6 hrs. AMA Cat. 1. **Fee:** $35. **Sponsor, contact:** Indiana Univ. School of Med., Div. of Postgrad. & CME, 1100 W. Michigan St., Indianapolis, IN 46202. **Co-sponsor:** Indiana Chapter of the Arthritis Foundation.

Medicine and Surgery

AMERICAN SOCIETY OF CONTEMPORARY MEDICINE AND SURGERY
For: All Physicians. Lectures, small group & individual conferences, workshop. Feb. 1-6. 8:00-6:00 PM. Chicago. **CME Credit:** AMA Cat. 1. **Sponsor, contact:** American Society of Contemporary Medicine & Surgery, 30 N. Michigan, Chicago, IL. Attn: John Bellow, M.D., Director.

CONTEMPORARY MEDICINE AND SURGERY
For: Practicing Physicians. Annual meeting and scientific assembly. Feb. 29-March 5. **Speaker:** Leon O. Jacobson, M.D., Dean, U of Chicago Medical School. **CME Credit:** 40 hrs. AMA Cat. 1; 30 hrs. AAFP Elective. **Fee:** $150-Members; $225-Non-members. **Reg. Deadline:** Feb. 15. **Sponsor, contact:** American Society of Contemporary Medicine & Surgery, 30 N. Michigan, Rm. 1506, Chicago, IL 60602. Attn: John Bellows, M.D., Ph.D.

Musculoskeletal and General Surgery Trauma

CLINICAL HOSPITAL PROGRAM ON MUSCULOSKELETAL AND GENERAL SURGERY TRAUMA
For: All physicians, residents, and interns. 2-hour Evening Clinical Program. Feb. 17. Loyola Univ. Med. Center, Maywood. **CME Credit:** 2 hrs. AMA Cat. 1; AAFP. **Sponsor, contact:** Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. Attn: Mrs. Lillian Husa, Exec. Sec.

Neurology

REVIEW COURSE IN NEUROLOGICAL SURGERY
For: Neurologists. 10-day course. Feb. 6-15. Chicago. **CME Credit:** 95 hrs. AMA Cat. 1. **Fee:** $400. **Reg. Limit:** 200. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612.

Pediatrics

SPECIALTY REVIEW COURSE IN PEDIATRIC SURGERY
For: Pediatricians. 5-day course. Feb. 16-20. Chicago. **CME Credit:** 38 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 85. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612.

MEDICAL-LEGAL PROBLEMS OF PEDIATRICS
For: Pediatricians. Monthly dinner meeting/lecture. Feb. 17. 8:00 PM. Holiday Inn, Chicago. **Speaker:** Philip Corboy, Attorney at Law. **Sponsor, contact:** Chicago Pediatric Society, 2800 W. 87th St., Chicago 60652. Attn: Thomas Driscoll, M.D. (for dinner reservations).

Psychiatry

INDIAN MEDICINE—EAST & WEST
For: Physicians, Mental Health Professionals. Lecture series. Feb. 4. 7:30-9:30 PM. Des Plaines. **Speaker:** Robert Bergman, M.D., Director Psychiatric Residency Program. **CME Credit:** 2 hrs AMA Cat. 1; AAFP Elective. **Fee:** $90 (entire series); $15 (indiv. lectures). **Reg. Limit:** 120. **Sponsor, contact:** Forest Hospital Foundation, 555 Wilson Lane, Des Plaines, IL 60016. Attn: June Bengsten. **Co-sponsor:** Chgo Medical School, Dept. of Psychiatry.

ACCOUNTABILITY TO WHOM, BY WHOM, FOR WHOM?
For: Psychiatrists. Distinguished lecture series. Feb. 18. 8:00 PM. Chicago. **Speaker:** Robert Gibson, M.D. **CME Credit:** 1½ hrs. AMA Cat. 1. **Fee:** None. **Sponsor, contact:** Institute of Psychiatry-Northwestern U. Med. School, 320 E. Huron, Chicago 60611.

Sexual Dysfunction

HUMAN SEXUAL DYSFUNCTION
For: Mental Health Treatment Professionals. Symposium. Feb. 18. 1:00-4:00 PM. Forest Park. **Speaker:** Samuel Liber, M.D., Riveredge Hosp. **Fee:** $10. **Reg. Limit:** 204; reservations req. **Sponsor, contact:** Riveredge Hosp. Foundation, 8311 W. Roosevelt Rd., Forest Park, IL 60130.

Surgery and Medicine

SURGICAL AND MEDICAL TREATMENT OF THYROID DISEASE
For: All MDs. Symposium. Feb. 18. 2:00-5:00 PM. Glen Ellyn. **Speaker:** Leslie DeGroot, U of Chicago. **CME Credit:** 3 hrs. AMA Cat. 1; AAFP Elective. **Fee:** None. **Sponsor, contact:** DuPage County Medical Society, 646 Roosevelt Rd., Glen Ellyn, IL 60137.

The Network for Continuing Medical Education has recently added a *self-assessment testing mechanism* to its service, which enables individual physicians to test their knowledge of NCME teaching points and maintain a record of participation. This quiz, plus co-sponsorship, make many NCME programs acceptable for AMA Category 1 CME credit. For further information, contact: Network for Continuing Medical Education, 15 Columbus Circle, New York City 10023.

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Increasing the Cost of Medical Care

It is no news that the exigencies of technologic progress are becoming increasingly unbearable. Every new elaborate procedure that, like endoscopic pancreatocholangiography, makes possible what previously seemed impossible boosts the soaring price of medical care and further encroaches on the accessibility of the medical professional. Doctors deprecate the planner who has little experience in direct care of patients, but someone has to assign priorities, has to balance costs and yields, and has to organize. For the sake of the victims of accidents, of coronary disease, of peptic ulcer, of renal-tract infection, of the varieties of arthritis, and of all those who need that frequently unattainable "primary care," planning is mandatory. Some disinterested "pointy head" may argue with considerable justification that not every physician who wants to be a Kasugai should be one. And another, following the lead of Spiro,[1] might even ask why endoscopic proficiency at finding and intubating the papilla of Vater requires an M.D. degree. (F. J. Inglefinger: "Endoscopic Pancreatocholangiography: Progress and Problem." *New England Jl. of Medicine* (Oct. 26) 1972 (Editorials) pgs. 879-880).

Reference

1. Spiro, H. M.: "Sigmoidoscopy by Paramedical personnel." *New England Jl. Med.* 275:1386, 1966.

COOK COUNTY

Graduate School of Medicine

CONTINUING EDUCATION COURSES
STARTING DATES — 1975-1976

SPECIALTY REVIEW IN SURGERY, PART II, Dec. 1 & March 8, 1976
SPECIALTY REVIEW IN PEDIATRIC SURGERY, February 16, 1976
SPECIALTY REVIEW IN THORACIC SURGERY, February 23, 1976
GENERAL PEDIATRICS, One Week, November 10
RECENT ADVANCES IN PSYCHIATRY, One Week, November 10
ADVANCES IN INTERNAL MEDICINE, One Week, November 17
ADVANCES IN OB-GYN, One Week, November 17
ANESTHESIA FOR HEAD & NECK SURGERY, Three Days, November 20
BASIC OBSTETRICS, One Week, December 1
REVIEW COURSE IN NEUROLOGIC SURGERY, February 6, 1976
BASIC ELECTROCARDIOGRAPHY, One Week, March 1, 1976
ADVANCES IN UROLOGY, Two Days, March 8, 1976
NEWER UROLOGIC INSTRUMENTATION, One Day, March 10, 1976
PEDIATRIC UROLOGY, Two Days, March 11, 1976
NEUROLOGY, BASIC, PART I, One Week, March 15, 1976
BASIC INTERNAL MEDICINE, One Week, March 15, 1976
NEUROPATHOLOGY, One Week, March 22, 1976

Information concerning numerous other continuation courses available upon request.

Address:
REGISTRAR, 707 South Wood Street, Chicago, Illinois 60612

BLUE SHIELD REPORT FOR Illinois Physicians

Changes in Federal Employees Health Benefit Program

The following Blue Cross and Blue Shield benefit changes have been made in the Federal Employees Health Benefit Program, effective January 1, 1976. The changes will apply to both High and Low Option plans for employees and family members.

(1) *Physical Therapy Admissions:*

Medically necessary hospital admissions and related inhospital physician care for physical therapy will be covered by Basic hospital and Basic surgical-medical benefits.

(2) *Private Room:*

Use of a private room during a covered admission is in benefit when isolation is required to prevent contagion. New benefit will apply when (a) the patient requires isolation to protect other patients from contracting his illness, or (b) when isolation is necessary to protect the patient from contracting illnesses from other patients.

(3) *Coordination of Benefits—Private Room and Board:*

When the Federal Employees Program is the secondary carrier in COB cases Blue Cross-Blue Shield may consider charges for private room and unreplaced blood and provide benefits, either basic or supplemental, depending on which portion of the program covers the admission. The amount paid under FEP cannot exceed the amount the Plan would pay as primary carrier. Change applies only when FEP is the secondary carrier.

(4) *Routine Newborn Care:*

Basic surgical-medical benefits will be provided for the initial routine inhospital visit of the newborn by a physician. Routine follow-up visits are excluded.

(5) *Local Anesthesia During Normal Delivery Billed by Delivering Physician:*

Supplemental benefits will be provided for anesthesia rendered during normal delivery when performed and billed by the delivering physician or his assistant.

(6) *Hypnotherapy and Hypnosis:*

Treatment of nervous and mental illness with hypnotherapy and hypnosis is in benefit if the treatment is appropriate with the diagnosis. Benefit does not apply to hypnotherapy or hypnosis of the patient used as anesthesia.

(7) *Home Health Care:*

Home Health Care benefits will be provided for up to 90 days (High Option) and 30 days (Low Option) per confinement period for those patients who can be treated in their own homes by intensive home health care. Following discharge from a hospital for a covered admission, basic Blue Cross benefits provide for covered home health care services if (a) services are coordinated by hospital and billed by a home health care provider having a written agreement with a local Blue Cross Plan

(Continued on reverse side of page)

Changes in Federal Employees Health Benefit Program

(Continued from preceding page)

(b) the member remains under the care of the physician (c) the services provided are approved by the physician (d) medical evidence substantiates that the member would require further hospitalization if home health care was not available, and (e) this care begins within 36 hours after the hospital discharge.

(8) *Charges Incurred During Admission Not Medically Necessary:*

Benefits will be provided for charges incurred during admissions denied as not being medically necessary, if the services would have otherwise been covered on an out-patient basis. Basic benefits are provided for laboratory and X-ray services, use of operating and recovery room and other basic covered services. Supplemental benefits will be provided for drugs, medical supplies and other supplemental services. Charges for room and board will continue to be denied, and this change does not affect the FEP exclusions pertaining to a non-covered stay.

(9) *Outpatient Consultations:*

Basic surgical-medical benefits will be provided for medically necessary outpatient consultations by a physician when related to and performed within 72 hours of an accidental injury or onset of a medical emergency. This will be considered as part of the emergency treatment.

(10) *Prescription Drugs Billed by Nursing Home:*

Supplemental benefits will be provided for medically necessary prescription drugs provided and billed by a nursing home, Extended Care Facility, Skilled Nursing Facility or other institution that is not a hospital, as long as the facility is legally authorized to dispense drugs.

(11) *Prescription Drugs Purchased Outside United States:*

Regardless of where purchased, payment will be made for prescription drugs, which under Federal law of the United States, require a prescription.

(12) *Cosmetic Surgery and Dental Care Resulting From Accidental Injury:*

Benefits for cosmetic surgery or dental care resulting from an accidental injury will only be provided when the accidental injury occurred at the time the member was covered under any Plan of the Federal Employees Health Benefit program. There need not be evidence that the FEHBP coverage was continuous, but the member must be able to show that he was covered at the time of the accident.

(13) *Non-member Hospital Exclusion:*

Supplemental benefits will no longer be provided for the 20 percent inpatient and 10 percent outpatient balances on charges for services and supplies furnished in a non-member hospital. These balances will be the responsibility of the member.

Cardiac Pacemaker Evaluation Services Added Benefit to Chrysler Corp. Plan

Procedures relating to transtelephonic evaluation of cardiac pacemakers and pacemaker evaluation services furnished per clinic visit will be covered under improvements made to the Chrysler Corporation Employees Plan, effective October 1, 1975. The benefit is in addition to those announced in the October 1975 issue of the Blue Shield Report in the *Illinois Medical Journal.*

IMJ

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Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to:
G. D. Searle & Co.
Medical Department, Box 5110,
Chicago, Illinois 60680

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Editorial Notice

There has been a considerable increase in investigative efforts in the broad areas of immunopathology and oncology in recent years. This knowledge is not only of a purely academic nature, but also is significant in terms of present or potential application as an adjunct to therapy and to clinical management of patients. Much has appeared in the literature and the average member of the biomedical community may have become somewhat "bewildered" due to the increase of information.

In keeping with the *Journal's* efforts to provide the membership with the latest knowledge, the Publications Committee authorized a brief series of timely and concise articles in immunopathology and oncology. These will correlate basic and clinical investigations in a general, but meaningful, manner, with emphasis on existing or potential clinical application. The initiation of this series, entitled: "Seminars in Immunopathology and Oncology", under the contributing editorship of Richard J. Ablin, will be in January 1976.

ILLINOIS is the subject of

Outdoor Illinois Magazine

Everything and anything that makes our state different, unusual, enjoyable, interesting, noteworthy is covered. **People, places, time** and **things** which appeal to anyone interested in our cultured heritage.

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The addition of 'Dyrenium' (50 or 100 mg.) to furosemide (40 mg.) markedly increased sodium and water output in 10 normal volunteers, especially on the first day of administration. 'Dyrenium' also reduced kaliuresis in all subjects, completely blocking the kaliuretic effect of furosemide (40 mg.) in seven subjects.[1] Patients with fluid overload and abnormal physiology may respond differently from volunteers; therapy should be titrated to the individual.

1. Stote, et al.: Effect of Triamterene on Furosemide Induced Kaliuresis in Normal Volunteers, J. Int. Med. Res. 2:379-83, 1974.

Hyperkalemia can occur with any K^+-sparing agent, but it is rare if urinary output is adequate. Serum K^+ and BUN should be checked periodically; elderly, diabetics, or patie with suspected or confirmed renal insufficiency should be observed closely. When 'Dyrenium' is given with furosemic K^+ supplements should be discontinued, and not given unless hypokalemia develops or dietary potassium intake is markedly impaired.

See facing page for indications and brief summary of prescribing information.

Dyrenium®

brand of **triamterene**

Potassium-sparing adjunct to furosemide in cardiac edema.

Now in 50 mg. and 100 mg. capsules.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary

Indications: Edema associated with congestive heart failure, cirrhosis and nephrotic syndrome; steroid-induced edema, idiopathic edema, edema due to secondary hyperaldosteronism and edema resistant to other diuretic therapy.

Contraindications: Severe or progressive kidney disease or dysfunction (possible exception: nephrosis). Severe hepatic disease. Pre-existing elevated serum potassium. Hypersensitivity to the drug. Continued use in developing hyperkalemia. Do not give potassium supplements, either by drug or by diet.

Warnings: Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported. Check BUN and serum potassium periodically, especially in the elderly, diabetics, and those with suspected or confirmed renal insufficiency. Use in pregnancy only when essential to patient welfare.

Dyrenium (triamterene, SK&F) and spironolactone are not usually used concurrently; if they are, however, frequent serum potassium determinations are required.

Precautions: If hyperkalemia develops, withdraw the drug. The following may also occur: electrolyte imbalance, low-salt syndrome (with low salt intake), reversible mild nitrogen retention, decreasing alkali reserve with possible metabolic acidosis. Do periodic hematologic studies in cirrhotics with splenomegaly. Concomitant use with antihypertensive drugs may result in an additive hypotensive effect. When 'Dyrenium' is to be discontinued after intensive or prolonged therapy, withdraw gradually because of possible rebound kaliuresis.

Adverse Reactions: Diarrhea, nausea and vomiting (may indicate electrolyte imbalance), other gastrointestinal disturbances, weakness, headache, dry mouth, anaphylaxis, photosensitivity, elevated uric acid, rash.

Note: When combined with another diuretic, the initial dosage of each agent should be lower than recommended.

Supplied: 50 mg. capsules, in bottles of 100; 100 mg. capsules in bottles of 100, in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630

Subsidiary of SmithKline Corporation

Personal Proficiency Testing

Recently enacted in Illinois was P.A. 79-422. This mandates a survey of all physicians to identify those providing private office laboratory testing for their own patients. Those so identified will then be surveyed over the next three years to identify the quality of service. Ultimately the results will be used to determine if there is a need to mandate proficiency testing. Currently, Medicare regulations are being developed to indicate that private office laboratory services may not be reimbursed if quality services are not attested.

The ISMS Board of Trustees has encouraged voluntary participation in proficiency testing by physicians conducting laboratory services in their private offices. Proficiency testing has been required of private, commercial laboratories and hospital laboratories for some time.

At this time, there are three approved testing services in Illinois. You can write them and ask for information regarding services provided, costs, and availability.

The first of these has a specific program for physician office laboratories called PEP—Proficiency Evaluation Program, and costs $139 per year. This is available from the College of American Pathologists, 7400 N. Skokie Blvd., Skokie, 60076. Phone (312) 677-3500. Director is Sherry Janek.

The second program is that of the American Association of Bioanalysis, Prociency Testing Service, 105 West Elizabeth Street, Suite 107, Brownville, Texas 78520. Phone (512) 546-5315. The basic program costs $135 per year. Director is Nickolas T. Serafy.

The third program is that of the American Society of Internal Medicine. Information may be obtained from ASIM, 535 Central Tower Building, 703 Market St., San Francisco, Calif. 94103. The program, entitled Medical Laboratory Evaluation, is sectioned into categories of activity and costs between $58.00 and $245.00. Contact Peter L. Saras, M.D., Chairman, Laboratories Committee.

James E. Habegger, M.D., *Chairman*
ISMS Medical Legal Council

PMA Foundation to Award Six Medical Student Fellowships

The Pharmaceutical Manufacturers Association Foundation anounced that its Medical Student Research Fellowship program will award six one-year grants for the academic year beginning July 1, 1976.

PMA Foundation Executive Director, Thomas E. Hanrahan, said the $5,000 stipends will be awarded to medical students who plan to pursue careers in pharmacology-clinical pharmacology, and who will devote a year full-time to a specific research effort in these fields.

The program objective is to identify candidates who have substantial interest in research and teaching careers in pharmacology-clinical pharmacology, and who are likely to become leaders in these fields, Hanrahan said.

A candidate for the fellowship must be currently enrolled in a medical school and must have completed at least one year of the school curriculum. The student must be sponsored by the pharmacology program in his own school or by that of another institution in which his investigative project is to be undertaken.

"If the important discipline of pharmacology, and this includes clinical pharmacology, is to have an essential influx of medically-trained personnel in future years, it is vital that there be some means of promoting and identifying career interests in these areas. Recognizing this need, the PMA Foundation has awarded ten fellowships since the program began in 1974," Hanrahan said.

The deadline for applications is January 15, 1976. Awards will be announced by March 15, 1976.

KAY CIEL® ELIXIR
(potassium chloride) 10%

DESCRIPTION: Each 15 ml. (one tablespoonful) contains potassium chloride 1.5 Gms., supplying 20 mEq. of elemental potassium, and 20 mEq. of chloride, in a cherry-flavored, palatable base; alcohol 4%. Contains no sugar.

INDICATIONS: Treatment of potassium deficiency occurring especially during thiazide diuretic or corticosteroid therapy, digitalis intoxication, low dietary intake of potassium, or as a result of excessive vomiting and diarrhea. Other causes of hypokalemia are fistulae, laxative abuse, villous adenoma, familial periodic paralysis, hyperthyroid periodic paralysis, insulinoma, primary aldosteronism or secondary aldosteronism, Cushing's Disease, renal potassium wasting conditions such as potassium wasting nephritis, and alkalosis.

CONTRAINDICATIONS: Impaired renal function, untreated Addison's Disease, dehydration, heat cramps and hyperkalemia.

PRECAUTIONS: Potassium chloride should be administered with caution and adjusted to the requirements of the individual patient, since the amount of deficiency and corresponding daily dose is often not known. Excessive or even therapeutic doses may result in potassium intoxication. The patient should be checked frequently and periodic ECG and/or plasma potassium levels made. High plasma concentrations of potassium ion may cause cardiac depression, arrhythmias or arrest. Use with caution in patients with cardiac disease. In hypokalemic states, attention should be directed toward the correction of the frequently associated hypochloremic alkalosis.

ADVERSE REACTIONS: Vomiting, nausea, abdominal discomfort and diarrhea may occur. Symptoms and signs of potassium intoxication include listlessness, mental confusion, paresthesia of the extremities, weakness of the legs, flaccid paralysis, fall in blood pressure, cardiac arrhythmias, and heart block. When hyperkalemia exists, it should be promptly treated with the discontinuance of potassium administration or other steps to lower serum levels if indicated, since sudden shift in plasma levels may induce potentially dangerous cardiac arrhythmias.

DOSAGE AND ADMINISTRATION: One tablespoonful of 15 ml. (equal to 20 milliequivalents) diluted in a 4 ounce glass of water, tomato or orange juice twice daily after meals will be sufficient to replete potassium losses in most hypokalemia patients. Some patients (approximately 30 percent), will require a dose of 15 ml. t.i.d. to reverse diuretic-induced hypokalemia patients. However, these patients require close supervision to avoid the possibility of potassium intoxication. Patients should be cautioned to follow directions implicitly in regard to dilution of Kay Ciel Elixir to prevent gastrointestinal injury.

CAUTION: Federal Law prohibits dispensing without prescription.

HOW SUPPLIED: 16 FL. OZ. (473 ml.) (ONE PINT) and 128 FL. OZ. (3785 ml.) (ONE GALLON) bottles.

Cooper
Laboratories, Inc
Wayne, New Jersey 07470

BRIEF SUMMARY
(For full prescribing information, see package circular.)
PREMARIN®
(Conjugated Estrogens Tablets, U.S.P.)

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.
Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.
Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest
Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.
How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000.

No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000. 7352

PREMARIN®

BRAND OF CONJUGATED ESTROGENS TABLETS, U.S.P.

CONTAINS ONLY NATURAL ESTROGENS ...NO SYNTHETICS OR SUPPLEMENTS

Ayerst

AYERST LABORATORIES
New York, N.Y. 10017

Obituaries

****Buxbaum, Henry,** Chicago, died November 2, at the age of 81. He graduated from Chicago College of Medicine in 1917. Dr. Buxbaum was co-founder of the Chicago Maternity Center in 1923 and was past-president of the American College of Obstetrics and Gynecology.

****Chivers, Joseph,** California, died October 4, at the age of 84. He graduated from Rush Medical School in 1917.

****Curry, James,** Chicago, died October 28, at the age of 80. Dr. Curry graduated from Rush Medical in 1921.

****Knewitz, Otto,** Belleville, died October 12 at the age of 94. Dr. Knewitz graduated from Washington University in 1905.

****Kostka, Helen,** Park Ridge, died October 25 at the age of 72. She graduated from Rush Medical in 1929.

***Kreeger, Morris,** Chicago, died November 3 at the age of 65. He graduated from Jefferson University in 1935.

Mallingly, Louis, Red Bud, died October 9 at the age of 58. He graduated from St. Louis University in 1942.

***Millikan, Martin,** Evanston, died October 15 at the age of 62. Dr. Millikan graduated from Illinois University in 1942.

***McMillan, William,** Chicago, died November 11 at the age of 76. He graduated from Rush Medical in 1926.

***Petrone, Anthony,** Chicago, died November 11 at the age of 63. He graduated from Chicago Medical in 1936.

Roberts, Reno, Oak Park, passed away at the age of 84. Dr. Roberts was a graduate of Loyola University in 1921.

***Rutherford, Robert,** Chicago, died October 22 at the age of 63. He graduated from Northwestern in 1937. Dr. Rutherford was co-founder of Central Illinois Health Service and a past-president of St. Francis Hospital Medical Staff.

***Smith, Victor,** Newark, died September 22 at the age of 58. He graduated from Loyola in 1942.

**Indicates ISMS member*

***Indicates ISMS member and member of the Fifty Year Club*

DARVOCET-N® 100

propoxyphene napsylate with acetaminophen

Indication: For the relief of mild to moderate pain, either alone or accompanied by fever.

Contraindications: Hypersensitivity to propoxyphene or to acetaminophen.

Warnings: *Drug Dependence*—Propoxyphene can produce drug dependence characterized by psychic dependence and, less frequently, physical dependence and tolerance. Propoxyphene will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to that of codeine although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

Usage in Ambulatory Patients—Propoxyphene may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, such as driving a car or operating machinery. The patient should be cautioned accordingly.

Usage in Pregnancy—Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, propoxyphene should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Usage in Children—Propoxyphene is not recommended for use in children, because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric age group.

Precautions: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The central-nervous-system depressant effect of propoxyphene may be additive with that of other C.N.S. depressants.

Adverse Reactions: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, lightheadedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances.

The chronic ingestion of propoxyphene in doses exceeding 800 mg. per day has caused toxic psychoses and convulsions. [011375]

DARVON® COMPOUND-65

propoxyphene hydrochloride, aspirin, phenacetin, and caffeine

Indication: For the relief of mild to moderate pain.

Contraindication: Hypersensitivity to propoxyphene, aspirin, phenacetin, or caffeine.

Warnings: *Drug Dependence*—Propoxyphene can produce drug dependence characterized by psychic dependence and, less frequently, physical dependence and tolerance. Propoxyphene will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to that of codeine although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

Usage in Ambulatory Patients—Propoxyphene may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, such as driving a car or operating machinery. The patient should be cautioned accordingly.

Usage in Pregnancy—Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, propoxyphene should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Usage in Children—Propoxyphene is not recommended for use in children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric age group.

Salicylates should be used with extreme caution in the presence of peptic ulcer or coagulation abnormalities.

Precautions: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

The central-nervous-system depressant effect of propoxyphene may be additive with that of other C.N.S. depressants.

Phenacetin has been reported to damage the kidneys when taken in large amounts for a long time.

Salicylates may enhance the effect of anticoagulants and inhibit the uricosuric effect of uricosuric agents.

Adverse Reactions: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, lightheadedness. headache, weakness, euphoria, dysphoria, and minor visual disturbances.

The chronic ingestion of propoxyphene in doses exceeding 800 mg. per day has caused toxic psychoses and convulsions. [011376]

Lilly

Additional information available to the profession on request.

Eli Lilly and Company, Inc.
Indianapolis, Indiana 46206

500391

main purpose of drug information or the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with his agency saying, "this information is generally agreed upon and herefore it should be used," as long s our process for getting the information is sound.

Distribution of the information s a problem. In great measure it ould depend on the medication in uestion. For example, in the case f an injectable long-acting progesrone, we would think it mandatory issue two separate leaflets—a ort one for the patient to read bere getting the first shot and a long ne to take home in order to make a ecision about continuing therapy. this case, the information might e put directly on the package and ot removable at all. But for a mediation like an antihistamine this formation might be issued sepately, thus giving the physician the tion of distribution. This could eserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

ly the doctor can remove that fear 20 or 30 minutes of conversation.

I'm not suggesting that we thhold any information from the tient because, first of all, it would totally dishonest and secondly, it uld defeat the very purpose of the sert. I do think that a patient on the th control pill should know about e incidence of phlebothrombosis.

If you're going to tell a patient e incidence of serious adverse reions, then you have to tell him t a concerned medical decision s made to use a particular medion in his situation after careful nsideration of the incidence of mplications or side effects.

otionally unstable patients pose pecial problem

There are patients who, bese of severe emotional problems, uld not handle the information tained in a patient package int. Yet if we are going to have a kage insert at all, we just can't e two inserts. I think we might ply have to tell the families of se patients to remove the insert n the package.

al implications of the patient kage insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

Editorials



Lawyers Influence on Practice of Medicine

Physicians and lawyers do not think alike and at the present time the legal profession has been very successful in changing the way the majority of physicians practice. The skill and art of medicine is now geared to avoiding a malpractice situation. The change is not to our liking, because it results in a marked increase in the cost of medicine. The pretrial publicity of a malpractice suit hurts because the physician has not had the opportunity to present his side. In many instances it stems from the lawyers hope that the insurance company will convince the defendant to settle for a smaller sum, "by compromise and without trial." To the physician this often means admission of guilt, but unless it is done it stirs up a hornets nest.

How have the lawyers changed the way physicians are treating their patients? We learn from the experiences of those who have undergone litigation. Graves[1] recently told about a colleague of his who aspirated a breast cyst. Three years later she developed cancer of that breast and sued the surgeon for malpractice. The doctors in the community got the message. They no longer aspirate a cyst of the breast. They remove it.

A patient complains of vague pain in the lower, right quadrant of his abdomen. The doctor considers acute appendicitis but the findings are not definite, so he takes the "wait and watch" approach. However, this is not done anymore. The doctor removes the appendix and faces the music with the Issue Committee if it is normal. For the patient this is an unnecessary risk, but the physician cannot take a chance on being sued (and often ruined) because he waited 24 hours and the appendix became gangrenous or ruptured and an abscess developed.

The threat of a malpractice suit is leading more and more physicians to order expensive laboratory tests, even when the physician is sure of the diagnosis and additional tests are unnecessary. Lawyers tell us we can stay out of legal trouble by ordering lots of laboratory tests. Thus the legal profession indirectly tells us how to practice and the cost of medical care continues to rise.

Many malpractice suits are nuisance suits. They are settled out of court. According to Graves, insurance companies in California paid $23 million for settlement of nuisance claims and only $7 million for bonified claims. In my opinion we get very little help from many of our insurance companies.

Books have been written on how to avoid this type of litigation. We must admit that some doctors are sued because they lack skill and good judgement or are just plain dumb or shady. Others make their patients angry by being rude, arrogant, insensitive or by making false promises. Patients are not told about risks or reactions. Many people take it for granted that they will get well. When their health does not return within a reasonable time these people become angry. Doctors should be on the alert for potential "suers." They are ignorant of what the medical profession can or cannot do. Others are paranoid or feel guilty because they are personally responsible for their sickness. Still others blame the physicians for not making them better when they lose their job or business.

Oddly enough some team physicians have been sued by older or mediocre professional football players who have been hurt and failed to make a complete recovery. These athletes blame the doctor for cutting short their professional career. (Many of their managers are lawyers too.)

Physicians must know medicine and their patients. A frank, communicative, tactful, sensitive, and considerate physician rarely gets sued. Because medical malpractice has become a growing sector of trial law, doctors must be careful. The lawyer knows he is right and must protect the American people against the mistakes of the medical profession. He is getting more and more

(Continued on page 613)

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Jaundice After Enflurane Anesthesia

Hung S. Tsang, M.D./Aurora

The halogenated anesthetics that characterize today's practice of anesthesia have in common the fact that they may be associated with liver problems. Various degree of hepatic injury, ranging from slight alteration of liver enzyme functions to massive hepatic failure has been reported with administration of halothane,[2] Methoxylflurane,[3] and Fluroxene.[4]

Enflurane (Ethrane) a newer halogenated anesthetic agent, has become widely used with considerable safety in the past two years. In 1974 there were three cases reported that Enflurane can also cause hepatic dysfunction.[5-7]

Herein we described an additional patient who developed jaundice after Enflurane Anesthesia.

Case Report

A 37-year-old white female was admitted to the hospital on April 17, 1975 for an abdominal hysterectomy for the treatment of a large uterine fibroid. Past history revealed that she had had an appendectomy many years ago. She had a radical mastectomy in 1969 for carcinoma of the right breast, but postoperatively developed repetitious pulmonary embolization, even after proper anticoagulatant therapy. Immediate vena cava plication was carried out at that time and the subsequent course was uneventful. In 1971 she had a tubal ligation after the birth of her last child. She has also had two diagnostic therapeutic D&C's for menorrhagia. The last D&C was done about two years ago. All of her anesthetic histories were unremarkable. Enflurane was never used on any occasion.

Physical examination revealed a well developed, well nourished, slightly obese female, B.P. 110/80 mmhg, pulse 84/min, and temperature 98.6F. R.R. 16/min. Head and neck were essentially negative. The chest showed an excellently healed wound over the right breast area. Lungs were clear bilaterally and the heart had a normal sinus rhythm. The abdomen revealed that the uterus could be palpatated about halfway between the symphysis pubis and the umbilicus. A pelvic examination showed the uterus to be enlarged to about the size of three months gestation. Extremities were not swollen or edematous. Reflexes were normal. Laboratory findings on admission, including Hemogram, Urinalysis, Chest X-ray, electrocardiogram, electrolytes and liver function studies, were within normal limits.



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Course of Anesthesia

Preanesthetic medication consisted of demerol 50 mg, vistaril 25 mg, and atropine 0.4 mg. Anesthesia was induced with thiopental 500 mg and maintained with enflurane 1.5 to 2.5 per cent in nitrous oxide (60 per cent) and oxygen (40 percent). Succinylcholine was used for muscle relaxation. Two units of packed red cells were administered during the procedure. The course of anesthesia (three hours and thirty minutes) was uneventful, with no hypotension or use of other drugs. About eight hours postoperatively, the patient's temperature increased, with spikes as high as 101° to 102°F. orally over the next twelve days. This was accompanied by anorexia and malaise. Jaundice appeared on the fifth postoperative day. There was no evidence of wound, pulmonary or urinary tract infection. Postoperative hemoglobin was 11.1 gm/100 ml and the leukocyte count ranged from 3800 to 5700/cu mm. The eosinophil count was ranging from 0 to 4 (preoperatively also 4).

Liver function tests were markedly abnormal (Table I). A liver scan showed hepato-splenomegaly and changes compatible with diffuse hepatic parachymal disease. A lung scan was also done and suggested the possibility of pulmonary emboli. Because of the latter findings a venogram was obtained which revealed the vena cava to be effectively occluded from the patient's previous surgery. Serum for Hepatitis B antigen was negative and antimitochondrial antibodies were not present. A liver biopsy was not performed.

Table I
Laboratory Data

	Serum Albumin Gm/100 ml	Serum Bilirubin mg/100 ml	Alkaline Phosphate mU/ml	LDH mU/ml	SGOT mU/ml
Admission					
4-17-75	4.4	0.5	65	175	17.5
Postop.,					
4-24-75	3.7	3.1	146	370	82
4-27-75		7.2	155		66
4-29-75		4.6	160		114
4-30-75		3.7	180		111
5-2-75	2.5	1.9	200		52
5-6-75		1.8	115		32
5-7-75		1.4	110		24

During the febrile period, the patient received antibiotic therapy. By the 13th postoperative day she was finally afebrile and her jaundice was starting to clear. The patient was feeling quite well and was discharged on the 19th postoperative day with jaundice completely cleared.

Discussion

In this case, the signs and symptoms were similar to those seen with "halothane hepatitis,"[2] i.e. an unexplained fever postoperatively, followed by jaundice within a week post anesthesia. Elevation of liver enzymes and bilirubin level were noted. The eosinophyl count was not particularly elevated in this case. The simultaneous drop of the serum albumin level with the elevation of SGOT suggests direct hepatic injury.[8] However, the hepatic abnormalities in this patient may or may not have been related to the administration of enflurane. The possibility of residual halothane in the anesthetic apparatus may have been the precipitating factor.[9] Other causes of postanesthetic hepatic dysfunction, including pre existing liver disease, hypoxia, hypotension, blood transfusion reaction, adverse reaction to nonanesthetic drugs and sepsis can be excluded in this case. The possibility of viral hepatitis due to blood transfusion can not easily be ruled out. However, examination of our patient failed to demonstrate antimitochondrial antibodies and failure of detecting viral antibodies or antigen argue against viral hepatitis.

The extent of liver damage in this patient appeared to be minimal. This was indicated by the complete recovery and unremarkable elevation of enzyme levels as compared to the enzyme levels reported in other patients with massive postanesthetic hepatic necrosis following other types of halogenated anesthetic.[4,10,11]

Summary

It is now clear that unmodified anesthetic molecules of halothane, methoxyflurane and fluroxene are not hepatotoxic but that certain metabolites of these agents are potentially toxic to the liver in animals[12,13] and probably in man. Many inhalation anesthetic agents have been suspected of altering immunosuppressive action[14] as a mechanism of liver damage, although these characteristics have not yet been ascribed to enflurane.[15] But, since enflurane is one of the halogenated agents, it is indicated that any unexplained fever or jaundice following its use should be thoroughly investigated and taken into account when considering further exposure of a patient to such agents. ◄

References

A list of references for "Jaundice After Enflurane Anesthesia" can be obtained by writing: *IMJ*, 55 E. Monroe, Suite 3510, Chicago 60603.

The Psychological Reactions of Children to Burn Traumata: a Review

Part II

By Peter W. Breslin/Chicago

Part I of this article, published in the Illinois Medical Journal in November, 1975, dealt with the psychological and social reactions of children to burn injuries. Mr. Breslin referred to several studies that have been done among burned children. He discussed the types of burn occurrences, the stages through which a hospitalized child passes, the various reactions of children to injury and hospitalization, and the psychotic reactions among severely burned patients. Part II discuses the parents' reactions as they are part of the total emerging process.

When considering children's reactions to burn injuries, the parents must also be implicated. The child is not an isolated bio-psycho-social unit, nor are his parents nor his siblings. Taken together, this organizational network, known as the family, exerts powerful influences upon the biological, psychological, and social status and behavior of its members. Thus the injured child's reactions are in part a function of his parents' reactions.

The parents can either facilitate or inhibit a healthy adjustment on the part of the child. Also, though to perhaps a lesser extent, the child's reactions influence his parents' reactions. Taken together, we can assume that if the parents and child are generally well-adjusted, both will exhibit appropriate and adaptive responses to the trauma. They will be able to adapt successfully and continue functioning according to their talents, abilities, and limitations. If the parents or child are psychologically immature or in some other way pathologically oriented, the chances that some psychopathological correlate to the burn trauma will develop, are significantly enhanced. If the child is disturbed but not the parents, (for example, a mental retardate), the parents must exert a strong influence over their child in order to prevent a highly disorganizing psychological response to the burn debilitation.

Mothers Reactions

Woodward & Jackson's interviews elucidated feelings of guilt, anxiety, and frustration on the parts of mothers of burned children. A common response was self-deprecation—the feeling that she was an inadequate, inferior mother. These responses are appropriate to the situation. However one who exhibits extreme responses should be considered with concern. A notably pathognomic response was anger at the child for disappointing or letting the parents down. Vigliano et al. detected depression in eight of the ten study mothers they interviewed; two were described as having strong guilt feelings concerning their failure to protect the child from injury. Some suicide attempts were reportedly considered. In four of the ten instances, some type of marital discord developed subsequent to the burn injury.

Martin listed maternal reactions of protest, despair, and detachment, as well as guilt and separation anxiety during the initial phase of the ordeal, and later on, despair, depression, and withdrawal, often characterized by insomnia and anorexia. Some mothers attempted to defend themselves against anxiety and guilt by displacing them onto her mate, a sibling of the victim, or another. As was mentioned earlier,* the adaptive reactions of the victims were less successful in children whose mothers visited infrequently. She believes that most maternal reactions to hospitalization, especially with younger children, can be explained as a frustration of the mother's natural desire to "mother" her child, causing counter-reactions to the separation anxiety—detachment and withdrawal.

Family Disturbance as Cause

The question of a basic disturbance in the family system, including some sort of psychopathology in the parents, which may have led to the injured child's disturbance, if one exists, and/or to his actually having been injured, has been raised. In Woodward's sample, 60% of the mothers of the burned children seen said that they suffered from "upset nerves". (This term, though obviously vague and seemingly evasive and defensive, was never clarified.) These are the ones who tended to have emotionally disturbed children. It will be recalled that the mothers of 81% of her sample said that they believed their children to exhibit some disturb-

*Cf.. Part I of this review: Breslin, *IMJ*, 148:519-524, 1975.

ance subsequent to the injury, while only 17% of these 81% were thought to be premorbidly affected. Thus, all that can be justifiably concluded from Woodward's material is that maternal instability, hypertension, or some other disturbance often prevents her from interacting with her burned child in a manner conducive to the child's psychological adaptation. As a result, her immaturity or other problem left the child vulnerable to the development of a psychological disturbance, similar or otherwise.

Holter & Friedman found eight of the mothers of their 13 subjects (62%) to have psychiatric disturbances, three with depression, five with emotional disturbances, including two psychotics. In only three of the cases (23%) were the marriages considered stable. It will be recalled that they described less than one-fourth of their burn incident cases as accidental. The others were either situational crises, involving some family system pathology, or child abuse. Also, Galdston reported that 27% of his study children were fatherless; he blamed the greater majority of incidents on parental neglect, but stopped short of suggesting parental unconscious causation.

Bezzeg, however, is much more suggestive of such a possibility. Also not all authors are convinced that the parents of burn victims may be expected to evidence some disturbance more than the general population norm. Nelson & Palletta, for example, charactrized only one of their cases (0.2%) as true child abuse. On the other hand, it has already been demonstrated that these children do seem to be accident prone, which may not be expected if the parents are responsible. The parents of accident-victim children may compensate following recovery by being over-protective of the child.

How, then, can we characterize the families of burned children—or can they be characterized at all? Woodward's data, it is true, must be highly qualified since, as we have discussed, the opinions of mothers regarding psychopathology, either in themselves or in their children, cannot be regarded as highly objective, reliable, nor scientifically accurate. Nevertheless, her results are still suggestive. I believe that the families of burned children may be over-represented in the classification of families with interactional dysfunctions. This, however, cannot be assumed for every family with whom the psychiatrist attending a child burn victim comes into contact.

Perhaps Holter & Friedman's estimate of true accidents among child burn victims is much too low. What is needed is a well-controlled, highly objective study of a large, randomly selected population of child burn victims and their families in order to shed light upon these urgent dilemmas before us.

The Psychiatrist's Task

Lastly, a few authors have addressed themselves to the tasks of the psychiatrist in dealing with the child burn victim and his family. Needless to say, to these traumatized individuals, the assistance, patience, understanding, support, and, most of all, advice and insight of the child psychiatrist may make the difference between healthy and unhealthy adjustmet to the catastrophe.

Bernstein relates the psychiatrist's duties to his four stages of the hospitalized child. During the first, or immediate care phase, since the child is usually in the hands of the surgeon and his assistants, the psychiatrist's primary responsibility is to the victim's family. He may serve as a communications link to keep the family abreast of what exactly is taking place medically to save the child's life. In some cases, he may be the only one available to be a source of consolation and support to those waiting. His presence at this time can also serve to establish a relationship with the family for possible future availability.

In the postadmission phase, the child may be hallucinating and extremely anxious and disoriented. Here, the psychiatrist must help the parents and the victim with the task of mourning, including the need to initiate the long and taxing process of readjusting life goals, aspirations, and expectations, both for the child and his parents. It is necessary with severe burn victims to help them reconcile themselves with the fact that, unfortunate though it may be, their lives may be drastically changed by the incident. During the middle phase, the possibility of skin grafting may cause the parents to hope for some magical total cures. Usually, however, false hope eroded into apathy, despair, and depression, especially for the child.

By this time, the psychiatrist should know the family members well and have their confidence and trust. He must at this time more than any other help them to maintain a realistic perspective, both for the present and for the future. He should discuss the child's reactions, such as aggression, aloofness, or apathy, and help them to understand their causes, as well as their amelioration. The child, too, must be allowed to be heard; he should be helped to understand the

painful emotions which may be flooding him.

In the final phase, characterized notably by the preparation to return home, the psychiatrist assists the parents in learning to be maximally supportive. Concommitantly, he must help the child to be accepting of help without becoming excessively dependent. Another important transition which can cause problems is that from home care to the resumption of the unaffected life of the family.

Preparation for the Child's Return to Life

Guilt is still probably the main parental emotion concerning the child, and the doctor must help them to deal with this. Also, he must maintain with them a firm reality base, allowing no hope for magical reversal of what has taken place. Primary among his or the psychiatric social worker's duties are to assist in making plans for the child's return to school. Such a prospect may be anxiety-laden for the child who is visibly disfigured by scar tissue. If the child has been hospitalized for a long time, discharge from the hospital may cause him some detachment problems. These need to be handled. Psychiatric therapy sessions on an outpatient basis, possibly family therapy, should be discussed and recommended when indicated.

The psychiatrist must help all involved to look with practicality and, above all, realism toward the future. He can perform an invaluable service by being a communications link between the child, the parents, the hospital staff, and the medical care agents. He can also assist the staff of the burns unit in understanding the child's reactions and working with him in the most constructive manner.

The Psychiatrist's Role to the Child

Additionally, Long & Cope emphasize that, to the child, the medical and surgical treatment for his injuries are often a mysterious and highly frightening understaking. They can involve much misunderstanding on the child's part. The psychiatrist, if he has won the child's trust is in a position to describe what the treatment is for, what is being done, and why. Once the child understands the procedures and realizes that those caring for him are trying to help him get better even though it may be painful, he no longer fears the treatment so much, nor those rendering it, and may even assist them in it.

The psychiatrist must be skilled in determining how much to support the child, while at the same time setting limits for him. He cannot be allowed to think that he can now demand and receive anything he wants.[15] Both Nover and Galdston emphasize that the child often needs a great deal of help in readjusting to a body injury such as a burn. The term body image refers essentially to the child's awareness that he is a distinct entity, wih unique features, from which flows a personal identity. Needless to say, what one's own body looks like is very important to self-concept and self-acceptance. Psychoanalytically-oriented theorists would view disfigurement by burn injury as a type of object loss,[24] which can cause severe emotional reactions. The child may even reject his "new body" or feel alienated from it. The psychiatrist attending this child can be of great value in helping him to understand and, more importantly, accept his new body.

The Psychiatrist's Responsibility to the Parents

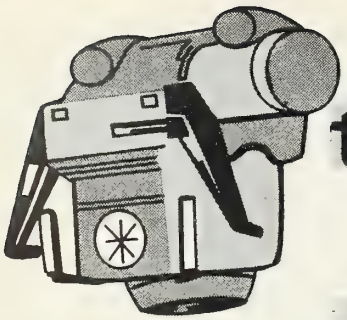
Perhaps the most valuable service that the psychiatrist can offer to the parents of most burn victims is sympathetic, supportive listening, if others such as relatives or close friends are not available. The parents often have a great need to talk to someone and the psychiatrist is usually one in whom they feel they can confide.

Program for the Child's Readjustment

Several noteworthy recommendations aimed at optimal intervention have been offered. Bezzeg's Child Life Program is aimed at the whole task of helping the child to come to terms with, accept, and act upon the changes which have taken place and are taking place in his life as a result of the injury, and to adjust his life and goals so that he might still live satisfactorily. In order to do this she believes the program staff must have some insight into the child's premorbid personality. Also, she advocates placing the child burn victim in pediatric wards of local hospitals, when and if possible. This would provide a more positive environment for the child, enable the parents to visit more readily, and, most of all, place the child in a "children's setting" and force him to deal with the task of psychosocial adjustment to his injured condition among his own peers. Thus he can begin to solve some of the problems he will encounter upon his return to normal life and school while he is still hospitalized.

Kjaer feels that the child patient can become unnecessarily over-dependent and regress if everything is done for him. He recommends having the patient do for himself as many basic func-

(Continued on page 602)



the view box

Leon Love, M.D./Chairman/Department of Radiology
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A 65-year-old female was referred to the hospital because of increasing respiratory distress and cough. She had also noted the development of hoarseness in the last six months. (Figures 1, 2 and 3)

What's your diagnosis?

1. Carcinoma of the lungs
2. Lymphoma
3. Intrathoracic thyroid
4. Thymoma

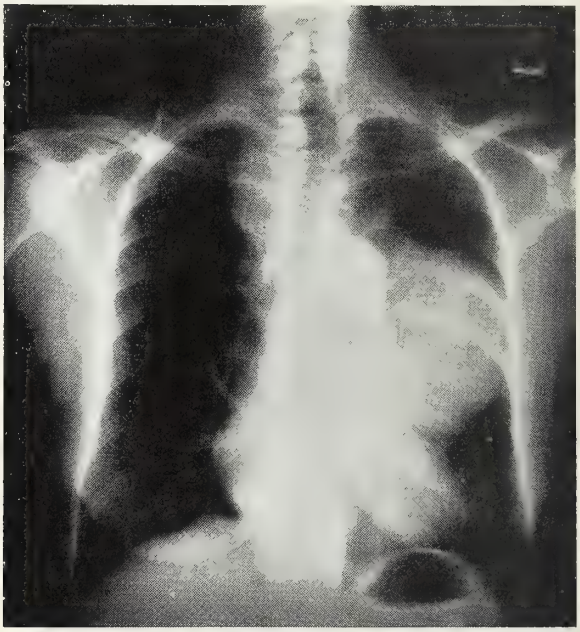


Figure 1

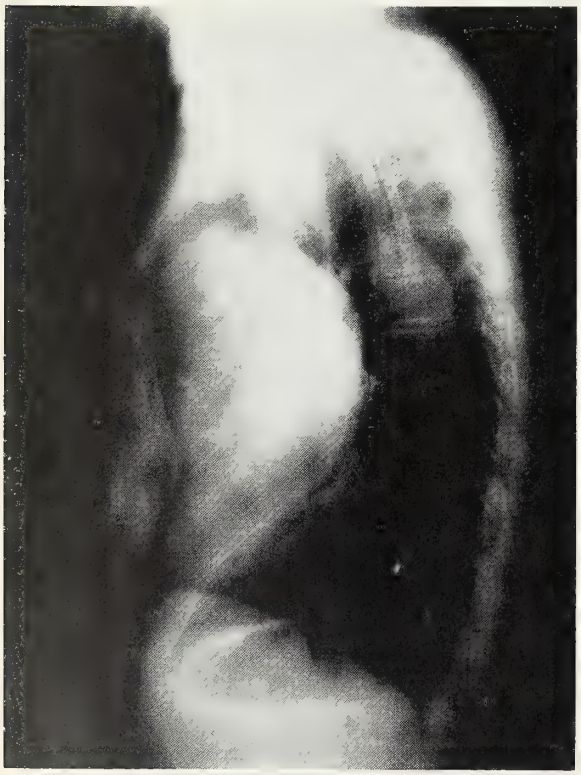


Figure 2

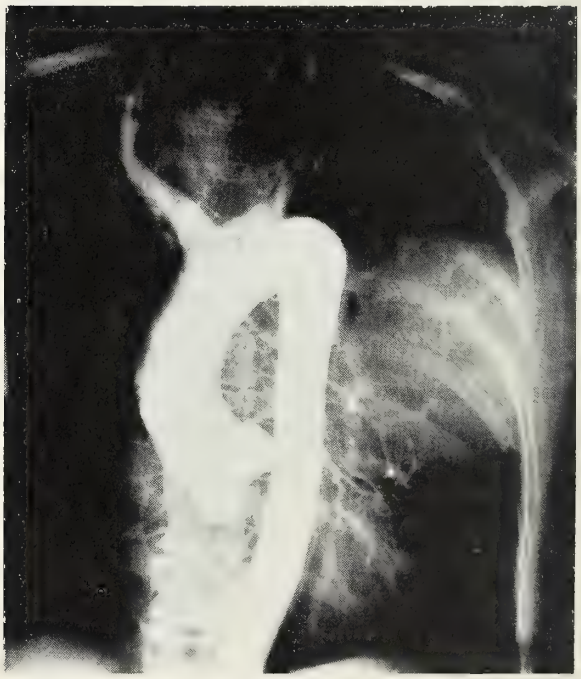


Figure 3

(Continued on page 602)

Azygos Venous Connection of Anomalous Inferior Vena Cava

By B. Agarwala, M.D., Rita Agarwala, M.D., and T. Baffes, M.D./Chicago

Two cases of severe congenital cardiac defects with anomalous inferior vena caval drainage by the azygos venous system into the superior vena cava are being reported. Different types of inferior vena cava drainage have been discussed with different types of associated congenital heart defects. The presence of this anomaly complicates cardiac catheterization procedure and increases the mortality and morbidity of the sick newborn infants. It is also pointed out that there is no radiographic appearance in the plane X-ray which may alert the pediatric cardiologist about its anomalous drainage.

The anomalous drainage of the inferior vena cava via the azygos system into the right atrium does not by itself cause any problem. However, it complicates cardiac catheterization of the right heart in infants and children. Our way of making a definitive diagnosis of the congenital heart disease mostly depends on a retrograde arterial catheterization and good cineangiographic pictures. The purpose of this report is to describe our experience with this combination of disorders in two children with severe congenital heart defects and also to point out that there is no radiographic appearance in the plane X-ray which may alert the pediatric cardiologist about its anomalous drainage.

Report of Cases

Case 1: An eight-year-old black male was admitted for second cardiac catheterization prior to total correction of his cyanotic congenital heart disease. He was born prematurely. Birth weight was 4 lbs., 7 ozs. There was no history of maternal Rubella during pregnancy. A heart murmur was noted at birth. His growth and development was slow. He developed congestive heart failure in early life. The first cardiac catheterization in May, 1967, at age 2 years, was via right saphenous vein was difficult because the inferior vena cava was draining anomalously by the azygos vein into the right superior vena cava (Fig. 1,2). The venous catheter could be advanced into the RA and RV with difficulty. Good angiographic picture within the right ventricle and also the retrograde arterial catheterization helped to make the diagnosis of ventricular septal defect with double chamber right ventricle. The digitals was discontinued later on. Recently he was noted to be bluer at rest and tired easily. No history of squatting or cyanotic spells were present.

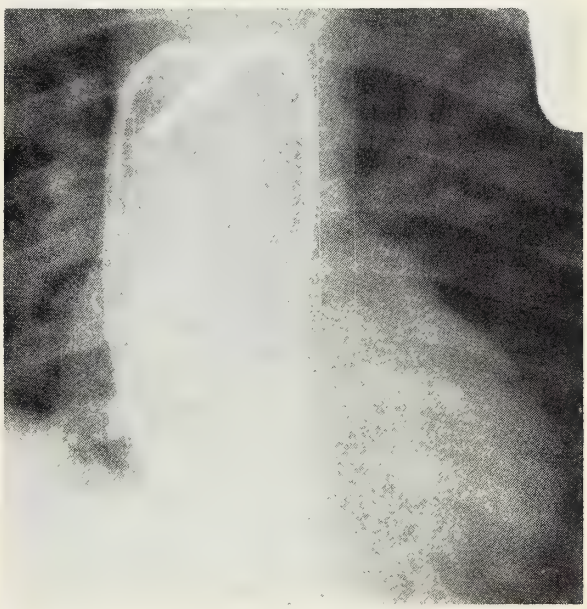


Figure 1. The venous catheter from the right saphenous vein entered the right atrium and the right ventricle via the azygos vein through the right sided superior vena cava. The arterial catheter tip is at the arch of the aorta.

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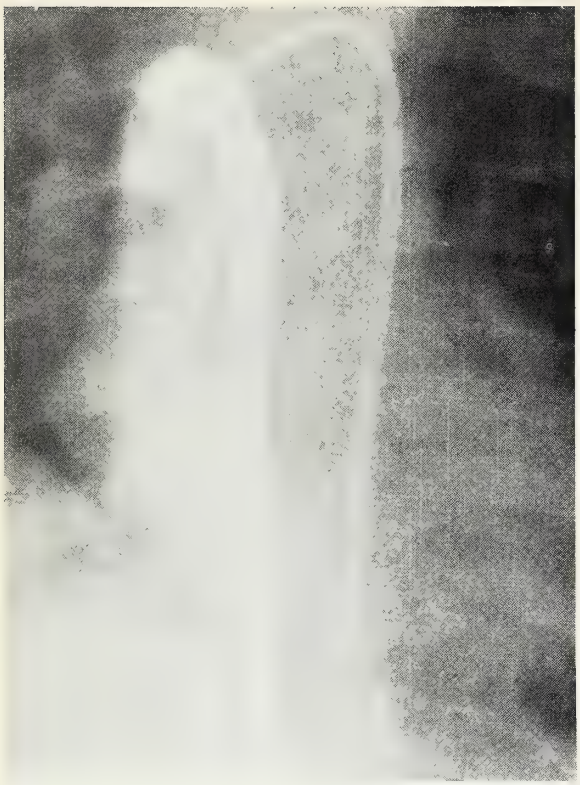


Figure 2. Contrast material injected into the inferior vena cava draining into the right sided superior vena cava via the azygos vein. The arterial catheter tip is at the arch of the aorta.

Physical Examination

On physical examination prior to second cardiac catheterization, this fairly intelligent but physically retarded eight year old boy was in no distress. Weight 38 lbs, height 44 inches, pulse rate 90/min., respiratory rate 20/min, blood pressure 85/50 mm Hg. No signs of overa infections were noted. Lungs were clear to auscultation. Abdomen was soft, not distended and not tender. There was no hepatosplenomegally. Moderate degree of cyanosis and clubbing were noted in the extremities. Peripheral pulses were normal.

On examination, the heart revealed the Precordial Maximal Impulse to be on the fifth left intercostal space just outside the mid-clavicular line. A parasternal heave and a systolic thrill was present at left 2nd and 3rd intercostal space. S_1—normal. S_2—both components were audible with diminished pulmonic component. S_3 was present at apex. A grade 4-5/6 ejection systolic murmur was best heard at left base with wide radiation all over the precordium. Diastole was clear.

Chest X-ray showed marked kyposcoliosis and rounding of the cardiac apex. Concavity of the left hilar region and diminished pulmonary vascularities were visualized. Electrocardiogram demonstrated evidence of normal sinus rhythm, right axis deviation, right atrial and right ventricular hypertrophy. Cardiac catheterization was performed using the right basalic vein and the diagnosis of tetralogy of Fallot was confirmed without any difficulty.

Another Case

Case 2: An eleven days old baby girl was born following normal full term pregnancy and delivery. A heart murmur was noted immediately after birth. She developed tachyapnea, tachycardia with enlarged liver on fourth day of life. She was digitalized and also received diuretics with initial response but the condition became worse later on when she underwent cardiac catheterization.

On Examination

She was a full term female newborn in moderate respiratory distress with intercostal and sub-sternal retractions. Heart rate, 120/min. Respiratory rate, 70/min. There were no signs of overt infection. Lungs were clear to auscultation. Abdomen was soft. Liver 5 cm and firm on right midclavicular line. Extremities showed no evidence of edema or clubbing. However, ashen grey color was noted. Peripheral pulses were weak all over.

On cardiac examination the Maximal Precordial Impulse was diffuse. No heave was palpable and a faint systolic thrill was noted along left ster-

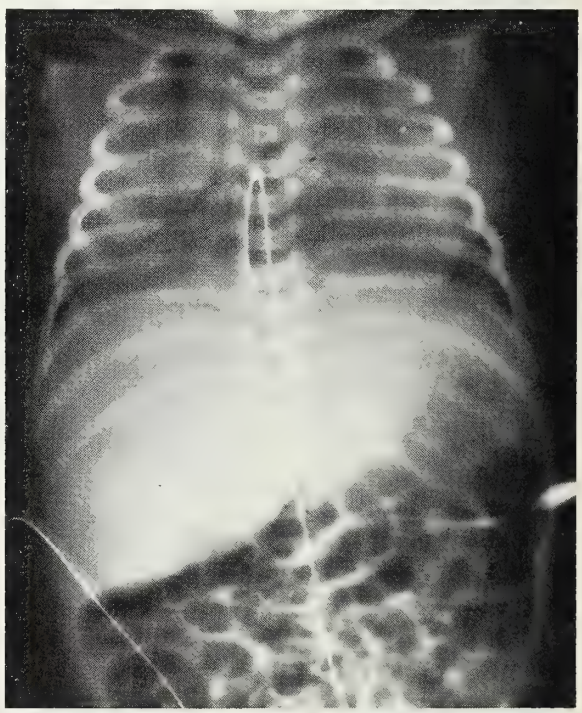


Figure 3. Plane X-ray film of the chest. The arterial catheter tip through the umbilical artery is coiled up in the descending thoracic aorta.

nal border. S_1—loud. S_2—single. A grade 4/6 holosystolic murmur was heard along the left sternal border with wide spread all over the precordium and left midaxillary region. Diastole was clear.

Electrocardiogram showed evidences of coronary sinus rhythm. Heart rate 100/min. Mean QRS axis was (—) 100 degree: qR in V_4R-V, was upright T. RS in V_5-V_6. This EKG was interpreted as left axis deviation with right ventricular hypertrophy. Chest X-ray showed cardiothoracic ratio 7.7 = 11, straightening of the left heart border, prominent right heart border and markedly increased pulmonary vascularities (Fig. 3).

The cardiac catheterization procedure became difficult when the venous catheter from the right saphenous vein took an abnormal course towards the left heart border. Dye injected into the inferior vena cava demonstrated its drainage into the persistent left superior vena cava which drained into the right atrium via the coronary sinus (Fig. 4). The catheter could not be advanced into the right atrium when the retrograde arterial catheterization was done. Left heart catheterization was completed. The cineangiogram in the ascending aorta confirmed the diagnosis of truncus arteriosus type I (Fig. 5).

Discussion

Anderson et al.[1] in 1961 reported 15 cases of the azygos and hemiazygos continuation of the inferior vena cava into the right superior vena cava and the persistent left superior vena cava. According to them, the incidence of this anomaly



Figure 4. Interior vena caval injection. The inferior vena cava is draining via the hemiazygos vein into the persistent left superior vena cava which is draining in the right atrium. The hepatic veins are opalified from the right atrium.



Figure 5. Arterial catheter tip at the origin of the truncus arteriosus. Main pulmonary artery coming out of the main trunk and dividing into two branches.

was approximately 0.6 per cent in patients with congenital cardiac anomalies. This anomaly is usually associated with severe congenital heart disease e.g. tetralogy of Fallot, atrioventricular canal, cor-biloculare, total anomalous pulmonary venous drainage, double outlet right ventricle, atrial septal defect, pulmonary stenosis or atresia and combination of these defects.

The inferior vena cava develops from several embryonic vascular structures e.g. supracardinal, subcardinal and posterior cardinal vein. Thus it is not surprising that many anomalies may arise during the process of its development.[2] The types of inferior vena cava anomalies described are:

1. The inferior vena cava may drain directly into the left atrium and produce cyanosis and polycythemia.
2. The hepatic vein and inferior vena cava may enter the right atrium separately, however, it does not cause any hemodynamic abnormalities.
3. The upper part of the inferior vena cava may be absent and drained by the azygos vein into the right sided superior vena cava or may be drained by the hemiazygos vein into the persistent left superior vena cava.
4. Sometime even though the inferior vena cava draines normally into the right atrium, it may stream its blood into the left atrium, when the prenatal flow from the inferior vena cava into the left atrium by patent foramen ovale persists.[3] Also the inferior vena caval blood may drain into the left

atrium through the low dorsally located interatrial septal defect, however in this situation, the large eustachion valves direct the blood from the inferior vena cava into the left atrium and the patient presents with cyanosis.

Cardiac Catheterization in Infants

In babies the cardiac catheterization is done through the groin using the saphenous or the femoral vein. With this approach all the right sided chambers, pulmonary arteries and usually the left atrium and left ventricle could be entered. Most of the time enough information could be obtained to make the definitive diagnosis; therefore, the risk of complications of the arterial catheterization could be avoided.

However, when the inferior vena cava drains anomalously the whole procedure becomes difficult. The use of femoral artery to complete the left heart catheterization could be of help to arrive at a definitive diagnosis. Sometimes the axillary vein also could be used but it necessitates another cut-down and prolonges the whole procedure which could increase the mortality in some of the sick newborns. To our knowledge, there is no definite radiological diagnostic findings described in plain X-ray of chest to detect the presence of anomalous drainage of the inferior vena cava. Such information would be very helpful to the pediatric cardiologist to perform cardiac catheterization using another vein in the arm and will shorten the procedure in sick newborn babies. ◄

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Burn Traumata

(Continued from page 597)

tional tasks as he is able to. He also lists ten "musts" to which the psychiatrist needs address himself in the psychologoical care of the patient. These are:

- —anticipate the patient's questions (help him to deal with anxiety and fears)
- —be sure that the psychological reactions do not interfere with the course of the physical remediation of the burn injury
- —be persuasive
- —set limits for the child's behavior
- —assist recovery by providing for adequate sensory input (a radio or television set)
- —see that the child gets adequate physical exercise
- —utilize physical and recreational therapy services liberally
- —organize group discussions sessions among child burn victims to allow them to express their fears and anxieties, get support and strength from others in the same position.
- —take enough time to develop a relationship of trust with the child and with his family
- —encourage visitors for the child, especially family members.

Conclusion

In the end, the psychiatrist might best approach the problem of dealing with the child burn victim and his family with the assistance of a psychiatric social worker, especially after the child has returned home following the period of hospitalization.[19] The emotional care of the child burn victim is a very delicate business at times. Understanding, patience, support, and genuine concern must be the psychiatrist's primary tools, both in dealing with the victim himself and also with his family. ◄

References

A list of references for "The Pychological Reactions of Children to Burn Traumata: a Review" may be obtained by writing: *IMJ*, 55 E. Monroe, Suite 3510, Chicago 60603.

Viewbox

(Continued from page 598)

DIAGNOSIS: *Intrathoracic thyroid*—A history revealed that the patient had had a previous thyroidectomy 17 years ago, at which time her chest was not explored. 75 to 80% of these masses arise from a lower pole or isthmus of the thyroid and extend into the anterior mediastinum in front of the trachea. The mass typically is well encapsulated, and may show calcifications.

An analysis of the film reveals that the mass is smooth in outline compressing the trachea to the left and extending across the left side of midline in the anterior mediastinum. A sliver-like density which is seen extending down from the left first rib toward the aortic knob represents the inferior thyroid artery, demonstrated on the aortic root study, (Figure 3) and supplying the huge mass. The aortogram demonstrated the thyroid component extending down from the neck and compressing the brachiocephalic vessels. Intrathoracic goiters usually are non-toxic nodules, although thyrotoxicosis is present in some cases; carcinoma is uncommon. At surgery a large benign intrathoracic thyroid was removed.

surgical grand rounds

Edited By John M. Beal, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of February 25, 1975.

Second Primary Lung Tumors

Dr. C. Andrew Heiskell: A 71-year-old white woman was admitted to Northwestern Memorial Hospital because of abnormalities detected by chest X-rays. She was asymptomatic. Her past history included hysterectomy for benign tumor and cholecystectomy for cholelithiasis. In 1971, a left upper lobectomy had been performed for small cell carcinoma of the lung. She was examined at three month intervals for two years without evidence of recurrent disease. She failed to report for approximately one year, but then appeared for routine examination. Examination was unremarkable. Chest roentgenograms were obtained.

Dr. Leonid Calenoff: The chest roentgenogram taken in February of 1974 (Fig. 1) shows postoperative changes secondary to left upper lobectomy: resection of the sixth rib, evaluation of the left hemidiaphragm and blunting of the costophrenic sinus. There are multiple calcified foci in and around the right hilar area. The lungs in general are clear.

The chest roentgenogram taken in January of 1975 (Fig. 2) reveals a 3x3x2.5 cm. mass located in the apical segment of the right lower lobe. The mass is slightly lobulated and shows no areas of breakdown. The calcifications seen in and about the mass were previously present. The mass has the appearance of a neoplastic process.

Dr. C. Andrew Heiskell: Because of these radiologic findings, the patient was admitted for further evaluations. Blood count and urinalysis

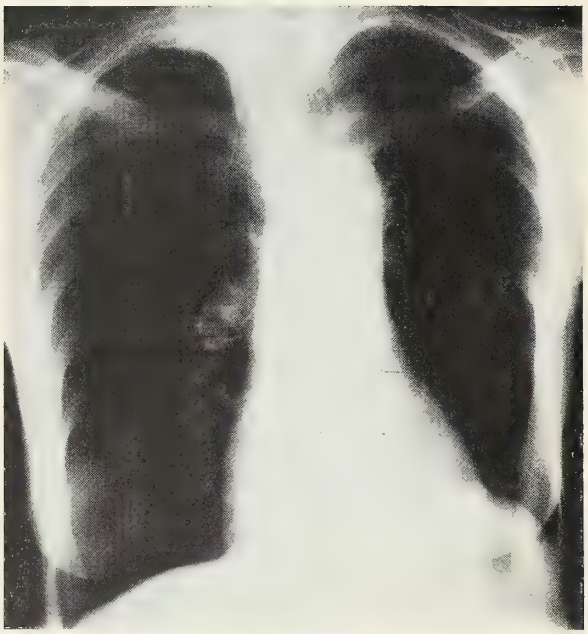


Figure 1. Chest film, taken February 6, 1974, showed postoperative changes secondary to left upper lobectomy but the lung field were clear.

were unremarkable. Her cardiac status was considered normal because she could climb three flights of steps without difficulty and the electrocardiogram was essentially normal. Liver function was normal. Blood urea nitrogen was slightly elevated, but serum creatnine was within normal limits. Blood gases were normal; her maximal breathing capacity was 65 percent, FEB I

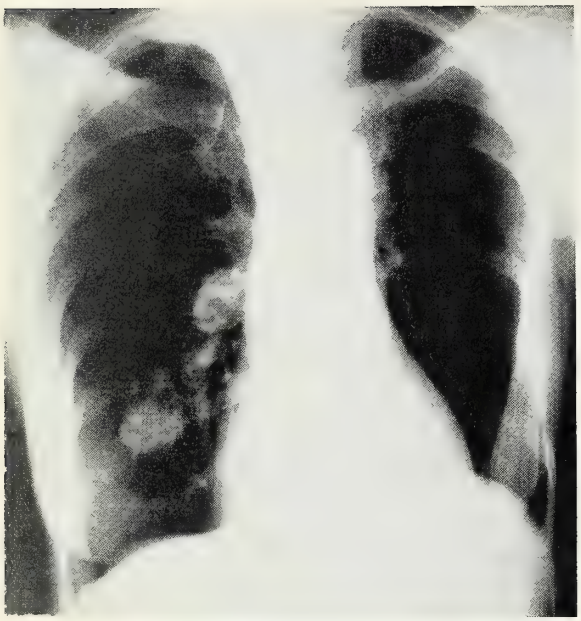


Figure 2. Chest roentgenogram, January 27, 1975, demonstrated mass in apical segment of right lower lobe.

was 72 percent, total lung capacity and FBC were normal. Cytologic study of sputum was negative for neoplastic cells. Bronchoscopy was performed and the tracheobronchial tree was normal. Cytologic study of bronchial washings was Class I.

Thoracotomy was performed. A tumor was found to lie adjacent to the common basilar bronchus just below the superior segmental bronchus and appeared to be localized without hilar or mediastinal adenopathy. The right lower lobe was removed. Postoperatively, the patient recovered well except for some problems with sputum production. She was discharged two weeks after operation.

Dr. Philip Coogan: The bulk of the current tumor had the histologic appearance of a poorly differentiated epidermoid carcinoma. (Figure 3). Multiple blocks of tumor were sampled and foci of poorly differentiated adenocarcinoma were occasionally encountered. Because of the admixture of squamous and glandular components, this tumor was ultimately designated an undifferentiated large cell carcinoma.

The lung tumor resected five years ago does not resemble the current tumor. It had a basaloid appearance quite distinct from the current tumor.

Dr. C. Andrew Heiskell: Double primary lung cancer is an interesting problem with a number of inherent diagnostic difficulties. Such tumors may appear simultaneously or metachronously so that the first problem is to decide whether these lung lesions represent metastases from an extra-pulmonary lesion, two new primaries, or one primary with a metastasis. The criteria for accepting both lesions as primary carcinoma has changed over the years. The first definition of double primary carcinoma apparently was that of Theodore Billroth in 1897, who stated that for two tumors in the same organ to be primary lesions, they must have different histologic patterns and different locations and each should produce its own metastases. This definition presents several practical problems. Clinically, it is undesirable to wait until each tumor has metastasized. Also, approximately 50 percent of carcinomas of the lung are squamous cell and, therefore, many would be expected to have very similar histologic patterns.

Over the past 50 years, the criteria have changed, based largely on the work of Warren and Gates, and currently we use the following relative criteria for the diagnosis of the second primary. It is helpful if each tumor has a different histologic appearance. An extra-pulmonary site of origin must be excluded. The longer the

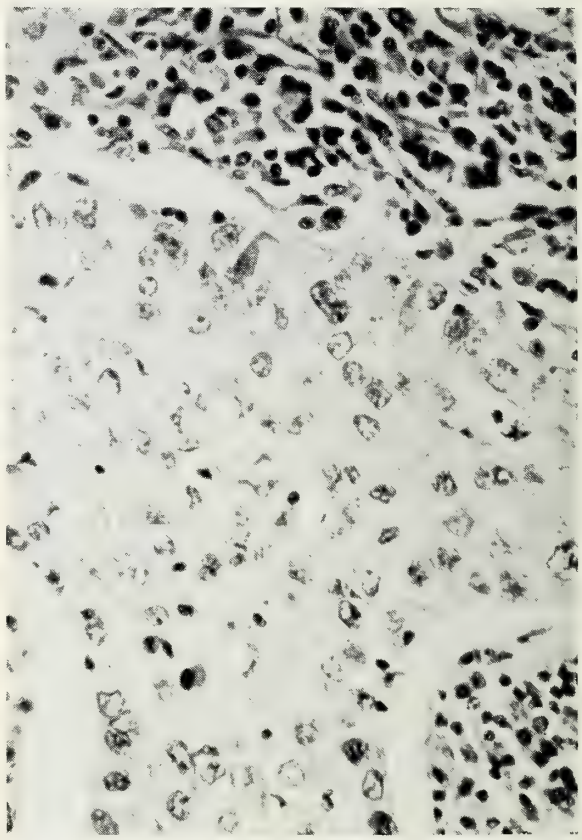


Figure 3. Microscopic study of the tumor demonstrated areas with the appearance of poorly differentiated epidermoid carcinoma.

interval between the appearance of the tumors, the more likely is the second lesion to be a second primary.

In 1964, Shields and Sherrick reviewed the literature in *Surgery, Gynecology and Obstetrics.* They found reports of only 53 cases of multiple primaries, 25 of which had been discovered at autopsy. Seven were discovered at autopsy following resection and only 21 had been discovered in living patients. Six were incidental findings, that is, a patient had a lung tumor resected, usually by pneumonectomy, and a second primary was found in the resected specimen.

Several other series have been reported. Smith reported a personal series of 964 patients in *Thorax* in 1970. In 1973, Shields reported again in *Surgery, Gynecology and Obstetrics* a Veterans Administration series of 2863 patients undergoing resection. Of these groups, 151 in the first report qualified as five-year survivors at the time of report and the incidence of second primary in this group was 9.2 percent. In the latter paper, 535 qualified as five-year survivors and the incidence of second primary was 7.6 percent. Thus, this should not be considered a rare or unusual occurrence, but rather a significant clinical problem.

The statistics are relatively uniform and indicate that one to two percent of all patients with carcinoma of the lung will have a second primary. Of the people who survive the first primary by three years, five to seven percent will develop another primary. Of the five-year survivors, eight to nine percent will develop a second primary.

Because the prognosis is somewhat poor in the patients with second primaries, we recommend a follow-up every three months for any patient who has had a resection. The patient should be seen for clinical evaluation and, obviously, chest X-ray. The chest X-ray should be done by the same laboratory and seen by the same radiologist, because these lesions should be picked up early. The old films should be available for comparison. Also, sputum cytology should be obtained every three months.

When the assumption has been made that a new tumor represents a second primary, the best treatment, as with the original primary, is surgical therapy, because it offers the best chance for cure. Again, a thorough preoperative evaluation should be performed and conservatism observed in the amount of resection.

Dr. Thomas Shields: Doctor Heiskell has summarized the problem very adequately. I think it should be emphasized that patients who are long term survivors of the initial resection for carcinoma of the lung are high risk individuals for the development of second primary lung lesion. Fortunately, today more and more of our patients are undergoing lobectomy, so a greater number of patients who do develop a second primary are potential candidates for definitive treatment. In the VA group, we could offer only 25 percent of the patients definitive therapy for their second lesion, mainly because the patients had had pneumonectomies and the second lesion was so placed in the main stem bronchus or major lobar bronchus that the indicated resection could not be accomplished safely. (Also, in a number of these patients, the second lesion was not identified until the patient returned for preterminal care.)

The problem is much simpler when the second primary occurs as a peripheral lesion. One can then frequently employ a conservative resection. Interestingly, I have had four patients who had had previous pneumonectomies and had developed second primary tumors, who I believed could undergo a second resection. In three of these patients, the lesion was peripheral and each patient underwent successful wedge or segmental resection of the lesion. One patient survived seven years after the resection of the second lesion and 13 years after the resection of the initial primary. The other patient died approximately two years after the resection of the primary and the most recent patient is 1½ years after a wedge resection of the second primary lesion.

In the fourth patient who had a pneumonectomy and whose pulmonary function was absolutely normal as far as values were obtained, I proceeded with a right lower lobectomy. This patient did well for approximately ten days but then died of cardiopulmonary collapse, the extent of the resection having severely compromised the size of the remaining pulmonary vascular bed. Obviously only a very limited resection will be tolerated by such patients. ◄

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Penetrating Injuries of the Thorax: Certain Aspects of Treatment

By Lawrence G. Khedroo, M.D., F.A.C.S./Chicago

Accurate evaluation and expeditious treatment of stab, gunshot, and blunt penetrating wounds of the chest require review and reassessment due to the ongoing prominent situation of high-speed vehicular accidents and inner urban violence. The short term ability of the central cardiovascular and ventilatory respiratory apparati to sustain morbid or mortal mechanical insult indicates the need for an available, understandable, and adaptable plan of treatment. The experience with such injuries is herein presented with emphasis on useful and veritable principles, plus documentation of some interesting variations of those cases in reference to clinical appearance and surgical therapeutics.

Initial Examination

In all instances of chest injuries, on the emergency triage level, initial assessment must be made of the central nervous, cardiovascular, respiratory, gastorintestinal, and genitourinary systems. These systems perform vital functions which need to be in continuous operation. Each has a vascular limit of impairment in reference to time. An anatomical systemic survey to determine thoracic injuries, must be made of the following areas: the heart and great vessels (pumping action, blood volume, peripheral vascular resistance), lung and tracheobronchial apparatus (ventilatory action, distribution, and diffusion of inspired air), esophagus (perforation and continuity), thoracic duct (continuity), spinal cord and bony column (continuity of spinal central nervous system), and thoracic wall (rib cage continuity and intactness). At the examination one must consider the hemopericardium, with or without cardiac tamponade; aorta, aortic arch vessels, or aortic rami division with hemothorax; blood loss with hemorrhagic shock; pneumothorax, with possible tension; mediastinal emphysema, due to tracheobronchial injury; anoxic anoxia with or without anemic anoxia; pleural effusion, secondary to esophagus perforation; chylothorax, secondary to thoracic duct torsion; and lower extremity paralysis, secondary to spinal column or spinal cord injury.

The initial treatment of chest, stab, and gunshot wounds is supportive. The inability of closed thoracotomy to cause lung reexpansion, acute cardiac tamponade or prominent hemopericardium, persistent intrathoracic blood accumulation (>25 cc/hour), stove-in-chest, and esophageal perforation are definite indications for surgical intervention. Closed thoracotomy is performed preferably with two tubes in order to expedite pleural drainage of bloody fluid and air. Surgical intervention can not wait for the patient to become cardiorespiratory-stable, but should be dictated by the patient's deteriorating condition.

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Selected Cases

Cases have been selected to illustrate and emphasize the (a) importance of ongoing repeat evaluation; (b) the efficacy of emergency closed two-tube thoracostomy; (c) arterial hypotension unaccompanied by accountable, reported, or observed blood loss; and (d) the applicability of thoracoabdominal surgical exposure for wounds involving the contiguous areas of chest and abdomen. (Table I)

In case #49978 (Fig. 1), a twenty-four year old male sustained a gunshot wound which penetrated the right chest, causing a hemopneumothorax and hemorrhagic shock. The missile stopped six centimeters to the left of the midline in a subcutaneous position after traversing the bony vertebral column at the level of the fourth thoracic vertebra. The patient was originally areflexic in his stuporous condition and had been maintained during the initial emergency treatment in a static supine position. A repeated neurological examination was not performed due to an over-concentration of treatment to the potentially lethal chest wound. In the post-operative

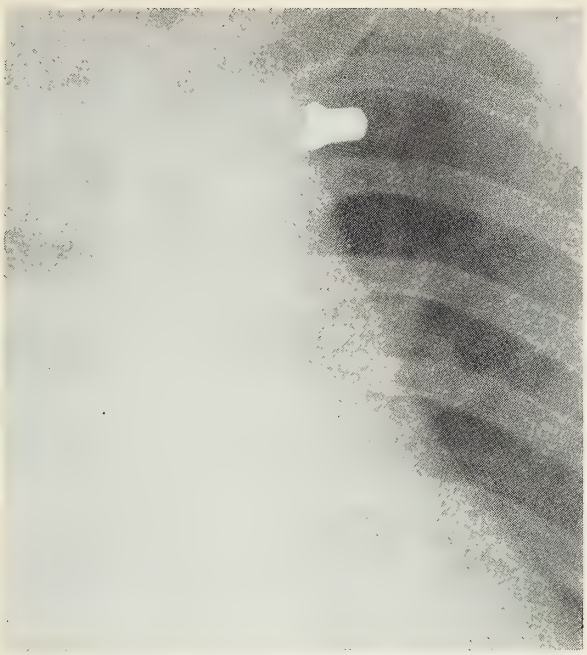


Figure 1—Case #49978. Chest X-ray demonstrates right hemothorax and foreign body (bullet) to left of body midline.

state a paralytic ileus occurred with extreme abdominal distention and persistent vomiting. This was treated unsuccessfully by trans-naso-oral gastrointestinal tube decompression. Twenty-four hours post-operatively, it was noticed that the patient had complete bilateral paralysis of the lower extremities and paresis of the upper extermities. The missile had transected the spinal cord in its right-to-left course.

In case #51495 (Fig. 2), a thirty-three year old male sustained a fractured skull, fractured right forearm, and multiple right rib fractures as a result of a thirty-foot fall. A flail chest was noted, accompanied by a right pneumothorax and subcutaneous emphysema. An emergency tracheostomy was performed. While rapidly organizing surgical treatment for the flail chest, the patient suddenly became pallid, semicomatose, and apneic. A diffuse right chest percussion disclosed hyper-resonance, indicative of a progressive tension pneumothorax. While still on the surgical cart, two mushroom catheters were rapidly introduced into the right pleural cavity without anesthesia. This procedure was accompanied by a noticeable expulsion of air per catheter, confirming intrapleural air under increased pressure. The closed thoracostomy catheters were attached to underseal water bottles. This procedure expeditiously alleviated the aforementioned symptoms and stabilized the ventilatory lung function. The stove-in-chest wall was stabilized. The patient gradually recovered and was discharged from the hospital in satisfactory condition.

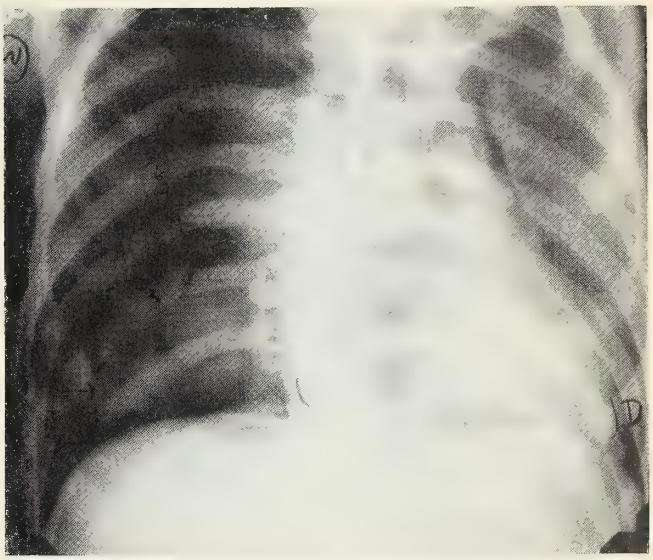


Figure 2—Case #51495. Chest X-ray demonstrates right tension pneumothorax (arrows), right rib fractures, and left medistinal contents shift.

Further Case Reports

In case #11913 (Fig. 3) a thirty year old male sustained a penetrating right chest gunshot wound. In addition to the hemothorax noted in the right thorax, symptoms of acute cardiac tamponade developed—distended neck veins, decrease in systemic blood pressure, decreased intensity of heart sounds—all in the absence of evidence of additional intracorporeal or extracorporeal blood loss. Under general anesthesia a rapid right thoracotomy revealed 500 ml. of blood loss in the pleural cavity. The dark bluish-

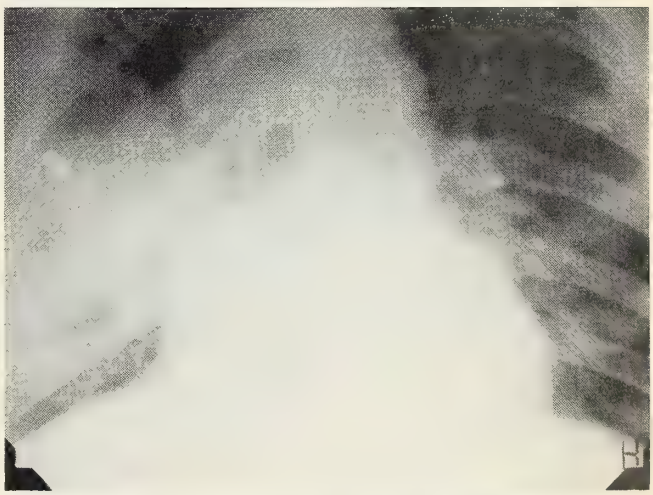


Figure 3—Case #11913. Chest X-ray demonstrates right lung hemorrhage and widened cardiac shadow due to hemopericardium.

Table I

Case—Injury	Blood loss due to trauma (blood transfused)	Surgical Treatment	Comments—Complications
16464—(G.) 54 M. L. thorax stab wound; hemothorax; abdomen stab wound; hemoperitoneum; subcutaneous emphysema; hemorrhagic shock.	1,800 ml. (2,000 ml.)	L. thoracotomy, tracheostomy, laparotomy, 2-tube L. thoracostomy	Self-limited bronchopleural fistula. Recovered.
24972—16 M. R. ventricle stab wound; hemopericardium; and L. hemothorax; hemorrhagic shock; L. Intercostal artery divided.	2,200 ml. (2,500 ml.)	L. thoracotomy, cardiorrhaphy, 2-tube L. thoracostomy, L. intercostal artery ligation	Paralytic ileus; L. leg phlebothrombosis. Recovered.
8887—26 M. R. thorax stab wound, with penetration of R. lower lung lobe; R. hemodiaphragm; R. lobe of liver; hemothorax and hemoperitoneum; hemorrhagic shock.	2,500 ml. (2,500 ml.)	R. thoracolaparotomy, repair of lung, diaphragm and liver, 2-tube thoracostomy	Hyperthermia 4 P.O. day. Recovered.
9515—29 M. L. part. chest and R. epigastric-abdominal stab wounds; liver and duodenum perforation; hemothorax.	1,200 ml. (1,500 ml.)	L. thoracolaparotomy, repair of lung, 2-tube thoracostomy, repair of liver and duodenal wounds	Recovered.
11913—(H) 30 M. Bullet wound, R. thorax and R. atrium; acute cardiac tamponade; hemothorax and hemopericardium; cardiogenic shock.	1,600 ml. (2,500 ml.)	R. thoracotomy, atrial repair, 2-tube thoracostomy	Recovered.
49978—(E) 24 M. Bullet wound, R. thorax; R. hemothorax and pneumothorax; hemorrhagic shock; paraplegia—spinal cord damage at 4th. thoracic vertebral level.	1,800 ml. (2,000 ml.)	R. thoracotomy, lung repair, 2-tube thoracostomy	Died; post-op. ileus with regurgitation and aspiration of vomitus.
51495—(D) 33 M. Flail chest; R. skull fracture; fracture R. ulna and radius; tension pneumothorax and subcutaneous emphysema. 30 foot fall.	100 ml.	2-tube closed thoracostomy—emergency—no anesthesia; emergency tracheostomy; chest wall stabilization	Recovered.
63522—(A) 20 M. R. thorax stab wound; hemothorax and pneumothorax; division of internal thoracic artery.	1,600 ml. (1,500 ml.)	R. thoracotomy, ligation of internal thoracic artery; 2-tube thoracostomy	Recovered.
90266—(F) 23 M. L. thorax stab wound; hemothorax; division of diaphragm and splenic pedicle vessels; hemoperitoneum; hemorrhagic shock.	2,800 ml. (3,000 ml.)	2-tube closed thoracostomy; laparotomy and splenectomy	Recovered.

13321—(C) 25 F. Bullet wound, L. supraclavicular region; tension pneumothorax; respiratory failure onset.	Minimal blood loss (>100 ml.)	2-tube closed thoracostomy—emergency	Recovered; secondary L. neck exploratory for removal of 2 foreign bodies.
1974—(I) 25 M. Gunshot wound, L. thorax and L. arm; tension pneumothorax; respiratory failure onset.	300 ml.	2-tube closed thoracostomy—emergency	Recovered; secondary exploration for partial R. upper arm radial nerve paralysis.
3334—(J) 26 F. Gunshot wound, epigastrium and L. thorax; perforation of liver, stomach, pancreas, and renal vascular pedicle; L. lung perforation with hemothorax.	1,500 ml. (2,000 ml.)	2-tube closed thoracostomy; L. renal pedicle area vascular repair; repair of liver, pancreas, stomach; splenectomy	Recovered; decreased L. renal function by intravenous pyelographic study.

white colored pericardium was opened and a gush of intrapericardial blood released. As soon as this occurred, the lowered blood pressure improved and, after careful surgical-field toilet and exposure, a five millimeter laceration of the right atrial wall was noted and repaired. His recovery was uneventful. The location of the atrial perforation was at the latter's juncture with the superior vena cava. No evidence of sino-auricular node injury was in evidence on electrocardiographic evaluation.

In case #3334 (Fig. 4) a twenty-six year old female sustained a perforating gunshot wound of the epigastrium through the left abdomen, exiting via the left erector spinae muscle group. In addition to a left hemothorax and evidence of hemorrhagic shock, gross blood was noted in the urine. The prime objective was considered to be the isolation and hemostatic mobilization of the left renal vascular pedicle. A left thoracoabdominal exposure was made. To gain the safest and least traumatic renal-pedicle access, a splenectomy was performed. In addition to perforating wounds of the left lobe of the liver, stomach, and pancreas, active bleeding renal arterial rami were observed. The kidney was divided horizontally almost completely in half, with the lower portion cyanotic in color. Mobilization of the renal artery-aorta juncture with vascular clamp temporary hemostasis permitted isolation, repair, and ligation of the renal vascular rami. The kidney was repaired by mattress through-and-through sutures. Fine silk was used to repair the renal pelvis. A post-operative intravenous pyleogram revealed partial renal pelvis visualization and dye excretion. The remaining contiguous organ perforations were suture repaired. The divided diaphragm permitted inspection and blood evacuation of the left thoarcic cavity. Appropriate drains and closed thoracostomy tubes were inserted. Recovery followed surgical repair. ◄

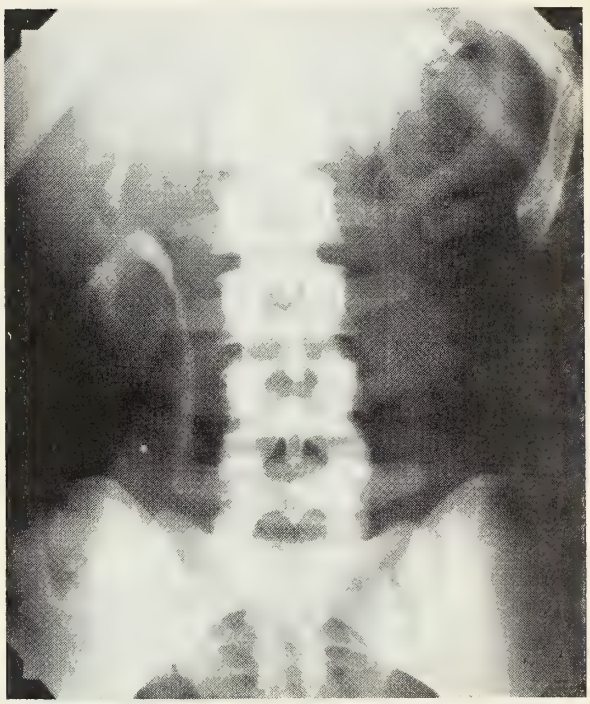


Figure 4—Case #3334. Intravenous pyelogram discloses intact right renal excretory system and faint visualization of intact left renal pelvo-ureteral conduit. Subsequent retrograde left pyelogram disclosed a deformed but intact left renal pelvis.

An Improved Gastrostomy Technique

By Robert E. Field, M.D., F.A.C.S. and
Raymond J. Romanus, M.D., F.A.C.S./Blue Island

Medical literature contains many descriptions of various techniques for gastrostomies. The object of all these various procedures is the same, that is, to establish a fistulous tract between the stomach and the surface of the abdominal wall so that the patient may be fed, or gastric drainage achieved. The purpose of this short presentation is to describe a simple, highly functional, well tolerated gastrostomy procedure which can be utilized for either feeding or drainage. The procedure is quickly performed, causes minimal trauma, and can be readily cared for by the patient or unskilled associates. We have utilized the GIA instrument manufactured by U.S. Surgical Company. Its most ideal indication would appear to be as a feeding gastrostomy.

Our experience with the instrument in such a procedure extends over a period of 24 months and includes nine patients. We have had no difficulty with the operation and the usual surgical time has not exceeded 20 minutes. Blood loss has been minimal. (Addendum: experience now extends over a period of 36 months and includes 14 patients.)

Technique

Routine preparation of the abdominal skin is as for any other abdominal surgical procedure. Anesthesia is that which is suitable for a procedure which will enter the abdominal cavity and will be of short duration. The incision is mid-line epigastric. The anterior wall of the stomach is grasped with Babcock forceps (3 to 4 in number) longitudinally at the most readily accessible portion of the stomach. The GIA instrument is then placed longitudinally along the fold of the elevated gastric wall from caphalad to caudad with the tips of the instrument pointing toward the pylorus. The instrument is activated, thus creating a tube of gastric wall approximately three inches in length, closed proximally and

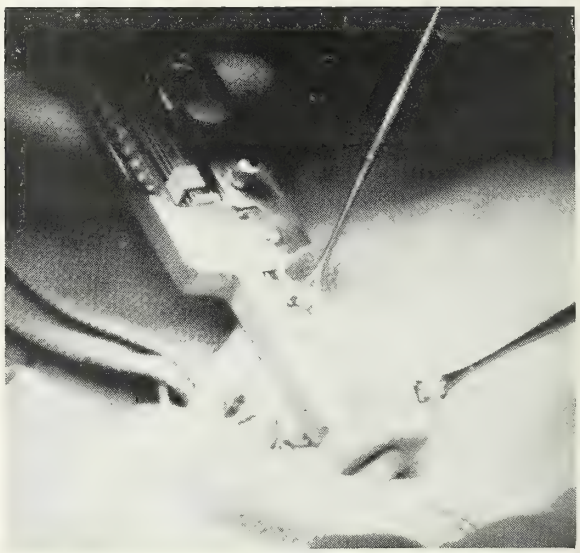


Figure 1

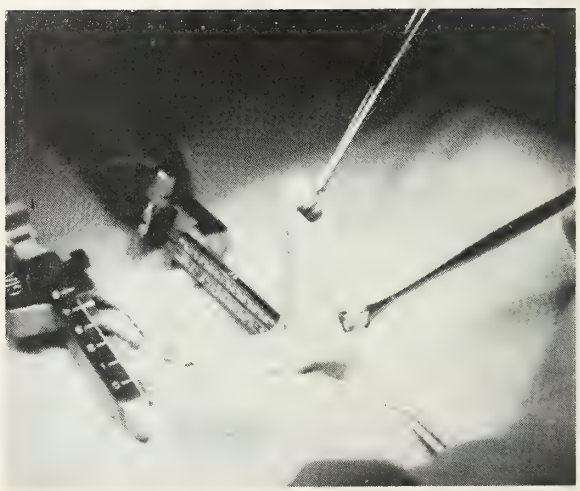
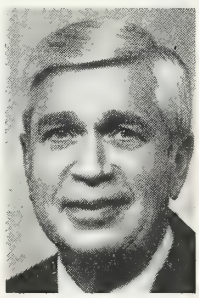


Figure 2



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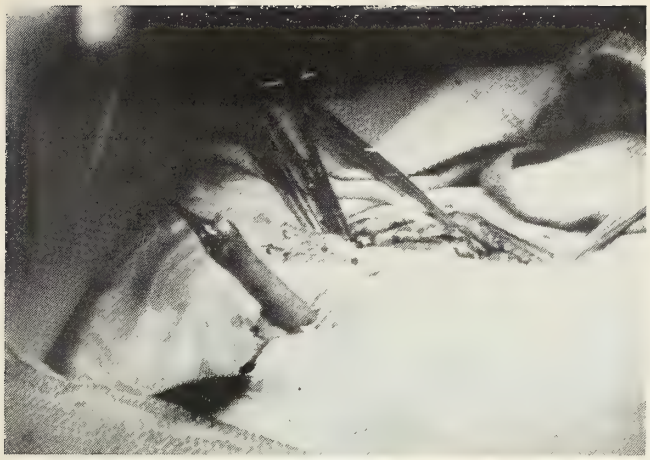


Figure 3

open distally into the stomach.

This tube is then brought out through a one inch long incision in left upper quadrant of abdomen and very superficially sutured to the adjacent skin. The abdominal wall is closed in whatever fashion the surgeon utilizes. The projecting tip of the gastric tube is opened at its distal end by a minimal amputative procedure. A suitable feeding catheter is placed in this tube and is automatically directed distally in the gastric lumen. It is ready to use for feeding within 24 hours. The gastric wall tube matures within three to four days. The contained tubing is readily replaced as needed by the nurse or by the patient. Inadvertent loss of the rubber tubing need not cause concern. Peripheral irritation of the skin has been minimal.

Summary

A technique of performing a permanent gastrostomy has been described. This is performed using the GIA instrument. The procedure performed is rather simple and does not require prolonged dissection or anesthesia. Very few sutures are required. It is a permament, mucus-lined gastrostomy which does not require the continuous placement of a catheter. It is also easily maintained by the patient. This technique could be advantageous by adding it to the surgeon's armamentarium. ◄

MD Licenses Revoked

A recent Illinois Department of Registration and Education (R&E) report revealed that R&E took disciplinary action—between August '74 through July '75—against 100 individuals licensed in 33 professions it regulates. Also, during August and September, R&E acted against five persons licensed under the Medical Practice Act. Included was the revocation of a chiropractor's license following his conviction on felony charges. Four MDs involved in disciplinary proceedings were:

Jan. 13, 1975	Valeriana Suarez, M.D. Chicago, Illinois License revoked after 1974 conviction on 34 Federal charges of illegal dispensing of controlled substances.
March 26, 1975	Norman Schwartz, M.D. Chicago, Illinois Voluntarily surrended license during appeal of 1972 conviction for murder.
April 22, 1975	Rudolph D'Elia, M.D. Peoria, Illinois Indefinite suspension after pleading quality to three charges of drug violations in circuit court one year earlier.
May 13, 1975	Payming Leu, M.D. Chicago, Illinois License revoked after being found guilty in Federal Court on 21 charges of illegally dispensing controlled substances.

None of the above were members of ISMS.

The action against Drs. Suarez and Leu resulted from a 1973 probe by the Illinois Legislative Investigating Commission (ILIC), headed by Charles Siragusa and chaired by Senator Philip Roch and Representative Joseph Sevcik. Also as a result of ILIC investigations, R&E has scheduled four hearings for November and December to act on complaints against physicians.

Basal Cell Epithelioma In Smallpox Vaccination Scar—Fifty Years Later*

By Myron H. Kulwin, M.D./Champaign

A seventy-five year old white male presented himself with a lesion on the deltoid surface of the left upper arm. He stated that this was the site of a smallpox vaccination he had been given at age twenty-four and it had not changed in appearance until approximately one year previous to his visit, at which time he noticed the development of some irregular thickening and crusting, all occurring within the confines of the original vaccination scar. A biopsy of the lesion showed the characteristic histopathologic changes of basal cell epithelioma, including atypical basal cells in the cutis in a primordial pattern. In addition, there was significant fibrosis.

We were interested, parenthetically, at this point, in comparing this specimen with a normal vaccination scar of approximately the same duration from an individual of approximately the same age. Fortunately, such a specimen became available to us from autopsy material. Microscopically, it showed an atrophic epidermis, loosely-arranged, pale-staining connective tissue of the subepidermal zone, and sparse adnexal structures.

The epitheliomatous mass was thoroughly curetted and electrodesiccated. Following healing of the biopsy and electrosurgical wound, the involved area was treated with 3000r of x-radiation at 90KVP, filtered through 1 mm. Al and fractionated into ten successive daily doses of 300r each.

Unique Feature

The feature of this case that intrigued us was the fact that epitheliomatous degeneration had occurred in this smallpox vaccination scar fifty years after the primary vaccination. This, indeed, is an unusual occurrences, as a summary of available literature (Table 1) indicates. The outstanding report in this tabulation is, obviously, that of Marmelzat,[1] based on a presentation made by him before this Society at its Tenth Anniversary meeting in 1967.

Table 1

Year	Author	BCE	SQCE	MEL	SARC
1943	Auger[4]	1			
1956	Rea[5]		1		
1960	Dorsey et al[6]	5			
1964	Marmelzat[7]			6	
1964	Coetzee[8]				1
1966	Goncalves[9]	1			
1967	Weary[10]	1			
1968	Marmelzat[1]	13	5	6	
1968	Zelickson[11]	1			
1968	Reed et al[3]	4	1	1	
1970	Riley[12]	1			
1971	Washington et al[13]	1			
1972	Finnerty et al[14]		2		
1973	Upton et al[15]	1			
1974	Gordon[16]	1			
1974	Kulwin	1			
Total by type:		31	9	13	1

Total reported: 54

It can be seen that a total of 54 cases of malignant degeneration in smallpox vaccination scars has been reported to date. Of similar interest is a breakdown of these tumors by histopathologic diagnosis.

Obviously, in view of the hundreds of millions, perhaps billions, of smallpox vaccinations which have been performed since 1900, the number of reported case of malignant degeneration is too small to ascribe any numerical relevance to antecedant vaccination. And yet, who can tell what potential exists for any given square centimeter of skin on the human body to undergo malignant change?

Interestingly enough, inquiry was made of the Bureau of Smallpox Eradication of the Center for Disease Control in Atlanta, concerning the



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**Presented before the Noah Worcester Dermatological Society at Marco Island, Florida, March 4, 1975.*

number of smallpox vaccinations performed in this country annually. The available data indicated that between 1962, the first year for which such information was supplied, and 1968, fifteen to twenty million units of smallpox vaccine were distributed in the United States annually. Since 1968, the number has steadily declined and in 1972 a mere five million units were distributed.

Malignant Change

Perhaps of more significance, however, is the fact that of 54 cases of malignant change, 13, or 24% were melanomas. Consider this figure in the light of data (Table 2) published by Haenzel[2] in 1965. This chart represents a considerably simplified version of a much more elaborate compilation of data published by the author. It is designed to point out the relative incidence of three types of malignancies as they occur in four populous northern cities as compared to four populous southern cities. As a rough guidline, it is apparent that the relative incidence of each of these tumors remains constant, even through a three-fold increase in magnitude when one moves from north to south. Furthermore, the incidence of melanoma remains at approximately 6%, which should be compared with the 24% incidence in lesions developing in smallpox vaccination scars.

Table 2

Incidence in 100,000 population

Type	North	South
BCE	28	102
SQCE	14	47
MEL	3 (6.6%)	9 (5.6%)
Total	45	158

Speculative Considerations

At this point, certain speculative considerations arise which merit emphasis because they raise the legitimate possibility of a post hoc relationship between these malignant changes and the prior introduction of the vaccinia virus into the skin. Reed[3] has pointed out and recalled the use of rabies vaccine almost 25 years ago by Pack and associates in the attempted treatment of melanoma and the subsequent attempts by Burdick and Hawk to treat this disease with intralesional injections of smallpox vaccine. Today, of course, studies are being carried out with the use of BCG vaccine to the same end. Does the virus, then, behave as a true carcinogen or cocarcinogen and is vaccinotherapy a truly etiologically oriented approach to the problem or rather a non-specific stimulator of response?

Marmelzat[1] most articulately suggests and discusses the pros and cons of several potential etiological factors such as viral effect, solar exposure in relation to the vaccination site, possible contact carcinogens, the carcinogenic effect of chronic scarring, and, finally, the possibility of pure chance.

What inferences, then, are we licensed to draw from these data and observations? I believe that two tentative conclusions are worthy of consideration. First, notwithstanding the highly questionable correlation between the number of cases that occur and number that are reported in the literature, the incidence of malignant degeneration is so low as to defy the establishment of any oncogenic relationship between such a tumor and the virus residing antecedently at the same locus. Rather, I would suggest that we are observing the well-established propensity of scar tissue to undergo malignant degeneration. Second, assuming that the published reports, while not recording all cases of malignant change in vaccination scars, do, at the very least, represent an approximate reflection of the various types and their true relative incidence, it becomes noteworthy to keep in mind the extremely high incidence of melanoma when such a degeneration does occur.

Editorial

Lawyers Influence

(Continoed from page 588)

education in school and in legal magazines on the handling of these cases. We still have ambulance chasers but many are switching to the more lucrative field of malpractice.

Doctors, including doctors with legal degrees, are also finding it rewarding. They are specializing in malpractice evaluation services. They act as consultants for lawyers in evaluating the patients chart and case history. They advertise in the magazine of the Association of Trial Lawyers of America. Their charges are high and it is very profitable—but in the long run it comes out of the settlement if the patient wins.

1. Graves, Clifford L., "On the Other Hand," *Medical World News*, Oct. 20, 1975.

T. R. Van Dellen, M.D.
Editor

The Adolescent who has Lost a Significant Other

By William Bauer, M.D./DeKalb

Self-defeating patterns of adjustment during adolescence seem to be related to parental loss sustained either prior to or during that period of development. The physical loss of a parent, or parental surrogate, by death (abondonment) or the emotional loss of a parent by dissolution of the primary emotional bond between parents are equally contributory. The devastating effects of early emotional loss have been variously promulgated.[1-4] *When a parent is lost through death or otherwise becomes unavailable emotionally, it is most helpful if the child can be prepared by as much open discussion as possible. This is evidenced by the following cases:*

Loss of a Father by Death

A 13-year-old white female was admitted to the hospital with a history of multiple self-inflicted lacerations of the wrists following a series of more subtle suicidal gestures. The child had been abandoned by her natural parents at an early age and was adopted, after two unsuccessful trials in foster homes, by a couple who had one son of their own.

When she was eight, her adopted father died rather suddenly with cancer. She had been very close to him and the mother "protected" her by not telling her anything about the seriousness of the illness until the day before the funeral. Following the father's death, the mother assumed a vengeful stance toward the child. During arguments she would tell the child that she was no longer a part of the family. The child began to fantasize about "joining father" by suicide whenever she felt hurt or rejected by the adopted mother. She told her therapist that she felt ill prepared for her father's death and was shocked by it.

Loss of a Mother by Death

A 14-year-old white female was found to be in conflict with her father. She had been arrested for possession of marijuana. The father was overtly rejecting in his manner toward the child. He demonstrated a marked coldness and lack of regard for or acceptance of her feelings. Two years before admission to the hospital, the child's mother had died of a lingering ilness but the child had never been made aware of the gravity of the situation. After the mother's death, the father became quite depressed and began drinking heavily, completely neglecting his daughter emotionally.

The child found it more and more difficult to approach him and eventually turned to peers for solace. She soon entered the drug world and became accustomed to escaping the deep feelings of rejection that she experienced, not only because of the "shock" of her mother's death but because of the sudden alienation of her father. She related to her therapist that she felt very much alone. She said that her father did not accept or understand her feelings of rejection and isolation. Her father removed her from the hospital against medical advice when she verbalized these feelings to him in a supportive therapy session.



WILLIAM BAUER, M.D., is an Attending Psychiatrist at Chicago Lakeshore Hospital and a consultant at Edgewater Hospital. He is also Chairman of the Adolescent Committee at Chicago Lakeshore Hospital.

Loss of a Series of Significant People

R—————— was a serious minded 17-year-old who had witnessed a parental divorce at the age of five but had never fully understood the reasons for this rupture in the family. He spent his summers with his father and stayed with his mother during the school months. The boy's maternal grandfather became very important to him after his father left the home. He was like a good friend to the boy in times of need. Then the grandfather died. Three months later, his father also died. R—————— was flown to his

father's funeral, flown back, and immediately put into school again. He had no time to experience grief on his own and did not feel comfortable enough with his mother to discuss his feelings with her. Concurrently he became quiet and withdrawn and began to isolate himself at school. He had few friends. Then he began to become suspicious of other and soon began to feel that people were talking about him. R—— was admitted to the psychiatric unit of the community hospital a while later. There he was given ample opportunity to articulate his repressed emotions. He was also started on a combination of phenothiazines which helped bring about a remission of symptoms fairly quickly.

When a marriage is dissolved or broken, it is important that adequate planning and communication be provided prior to the actual physical disruption so that the adolescent will have an opportunity to prepare himself for the "shock" of sudden estrangement and possible relocation to an alien environment.

Loss of Family by Divorce

A precocious, 14-year-old, white male was admitted for evaluation after he had dropped out of school and became a regular user of marijuana. He indicated to his therapist that he had absolutely no knowledge of the impending divorce of his parents. When it came, he suddenly found himself living alone with his father in a sleeping room. He lost contact with his old friends and began spending most of his time sleeping, smoking marijuana, or attempting to do some exercises in the YMCA. He said that he was confused and felt very bitter about the way he had suddenly been cast adrift.

When a parent suddenly withdraws from a child because of fortuitous circumstances or from a weakening of the primary marriage bond, the child is equally affected.[1]

Loss of a Parent Via Emotional Withdrawal

A 16-year-old white female was admitted to the hospital of her own volition because of intense feelings of lack of self esteem and fear of criticism in the class room situation. She had not gone to school successfully for two years prior to her admission.

A detailed social history revealed that the patient had found a younger brother dead in his crib when she was 8 years of age. Her father had immediately blamed her for the tragedy and overtly rejected her since that time. Because the father was not emotionally available to her through the years following that event, she was unable to communicate these feelings. When she became an adolescent, she began acting out in a way that would "punish" her father, i.e., taking drugs, dropping out of school (which he felt was very important) and going into the hospital.

The father and mother in this situation seemed to be at odds with each other about how to handle the child and were constantly arguing about what course to take.

Summary

It seems that a child who loses a significant adult at any time during the developmental period, especially if the loss is precipitous, is likely to experience adaptive failure during adolescence. This is especially true when the loss is compounded by a lack of emotional support from others in the environment. The child then begins to act out his grief, resentment, anger, and sense of loss in the only language that is available to him—symbolic behavior.

When the child is secure, as in a hospital facility, if he is able to articulate these repressed emotions, he is often relieved of the compulsion to act in nonadaptive patterns. ◄

References

1. Bauer, William: Legacy of Love: The Right to Mental Health, New York, Vantage Press, 1972.
2. Bowlby, John: Attachment and Loss, New York, Basic Books, Inc. 1969.
3. Masterson, James F.: Treatment of the Borderline Adolescent: A Developmental Approach, New York, Wiley-Interscience, 1972.
4. Spitz, Rene A.: The First Year of Life, New York, International Universities Press, Inc. 1965.

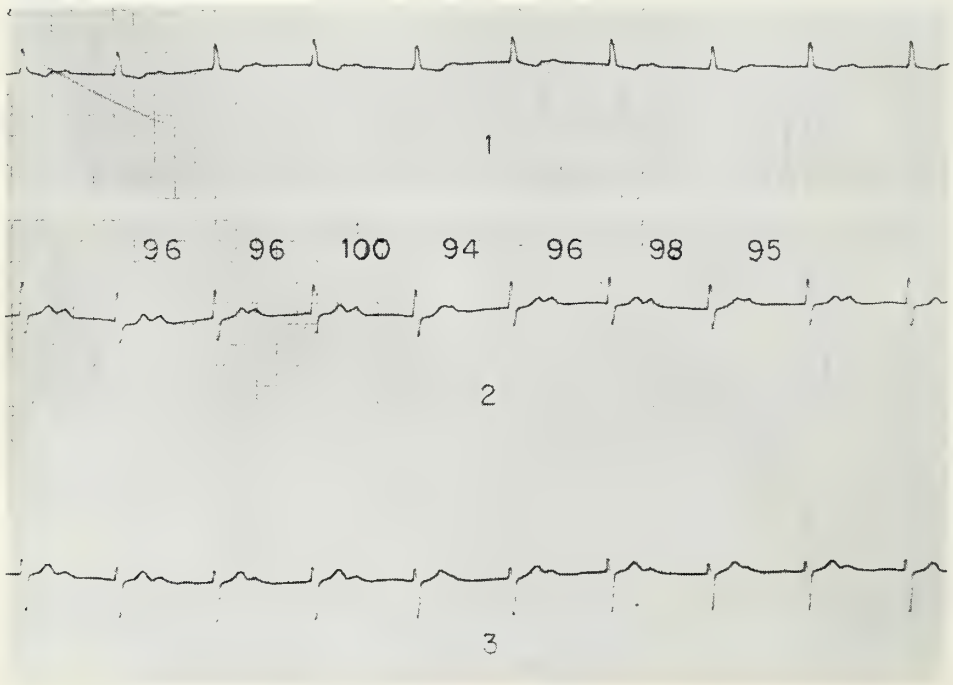
Danger of Welfare State

"There is an overriding danger inherent in the growth of an American welfare state. The danger simply is that we may undermine our whole economy. If social programs continue growing for the next two decades, at the same pace they have in the last two, we will spend more than half our gross national product for domestic social programs alone by the year 2000."—Caspar W. Weinberger, former secretary of Health, Education and Welfare.

ekg of the month

John R. Tobin, Jr., M.S., M.D., Rimgaudas Nemickas, M.D., Patrick J. Scanlon, M.D., John F. Moran, M.S., M.D., Sarah Johnson, M.D., and Rolf M. Gunnar, M.S., M.D./
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

A fifty-six year old man entered the hospital with symptoms of an acute myocardial infarction. He had an uncomplicated course in the hospital. The simultaneous three lead ECG rhythm strip was recorded on the tenth day post-myocardial infarction.



Questions:

1. The ECG rhythm strip shows:

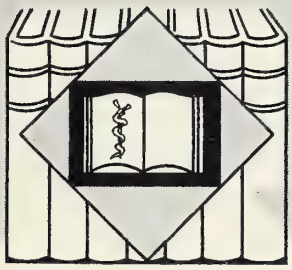
A. Junctional rhythm at a rate of 62 beats per minute.
B. Atrioventricular dissociation.
C. Sinus arrhythmia.
D. First degree atrioventricular block.
E. Q-T interval prolongation.

2. This ECG finding(s) may be seen in which of the following clinical settings?

A. Acute rheumatic fever.
B. Coronary artery disease, particularly acute inferior wall myocardial infarction.
C. Digitalis excess.
D. Aortic valve disease.
E. All of the above.

(Answers on page 618)

the doctor's library



REVIEW OF CURRENT PRACTICE IN ORTHOPAEDIC SURGERY, 1973. Editor: James P. Ahstrom, Jr., M.D. The C. V. Mosby Company, 1973.

This is the fifth volume in this series which attempts to discuss current and newer techniques in the diagnosis and treatment of orthopaedic disorders. The eleven chapters, each written by different contributors, are: Pollicization in Congenital Absence of the Thumb; Selected Observations on the Cervical Spine in the Child; Ligamentous Injuries of the Knee; Arthroscopy of the Knee; Management of Arthritis of the Knee Joint; Total Hip Replacement; Clinical Application of Polymethyl Methacrylate for Total Joint Replacement; Scoliosis in Cerebral Palsy; New Trends in the Operative Treatment of Scoliosis; Management of Low Back Pain; Orthopaedic Considerations in the Management of Muscular Dystrophy.

The authors are widely experienced in the treatment of the problems which they discuss and, therefore, their in-depth presentations of the topics are very useful. For the practitioner the chapters on arthroscopy of the knee by Dr. Robert W. Jackson, total hip replacement by Dr. Frank E. Stinchfield and associates, as well as the management of ligamentous injuries of the knee by Dr. Joseph D. Godfrey are of particular worth. Dr. Ian MacNab also has a valuable chapter on the management of low back pain, certainly a problem of almost epidemic proportions.

Overall, one can easily recommend this volume for those actively engaged in the clinical practice of orthopaedic surgery.

James W. Milgram, M.D.

VASCULAR SURGERY, Volume I: Peripheral Arterial Diseases. John J. Cranley, M.D. Harper and Row, 1972. First Edition, 282 Pages, List Price, $19.95.

During the last decade, surgical treatment for peripheral vascular disease has evolved into a specialty within the sphere of surgery. This volume, written by a vascular surgeon and his colleagues, is a welcome addition to the field.

Eleven chapters, covering various aspects of the surgical practice dealing with peripheral vascular problems, are included. One notable omission is a discussion of chronic mesenteric artery ischemia.

Surgical technique for each arterial reconstructive procedure is illustrated by excellent drawings. Although there is no mention of the technique used, nor of the indications for, arteriographic examination, pathologic findings are exemplified by superior reproductions of the arteriograms.

All chapters are well balanced and harmonious in their presentation. The only drawback is the lack of emphasis on the physiologic alterations of blood flow and pressure associated with arterial stenosis or occlusion of vessels supplying different vascular beds. A concise introduction on the importance of the hemodynamic aspects of vascular disease would be helpful to students and house staff in understanding the disease process. The description of laboratory evaluation in circulatory insufficiency also seems rather scant.

A unique feature of the volume is that each chapter is furnished with adequate references oriented toward surgical treatment. The book is recommended for trainees who are exposed to surgical treatment of peripheral vascular disease.

James S. T. Yao, M.D., Ph.D.

CURRENT SURGICAL DIAGNOSIS AND TREATMENT. Edited by J. Englebert Dunphy and Lawrence W. Way. 1108 Pages, Illustrated. $14.00. Lange Medical Publication, Los Altos, California. 1973.

This soft cover surgical textbook edited by J. Englebert Dunphy and Lawrence W. Way contains 52 well written and informative chapters. The chapters are well organized and the tables and illustrations add to the understanding of the material presented. The editors have accomplished their goal in presenting the essential and

most recent material in as concise a manner as possible. Besides the basic type of information found in all surgical texts, there are separate chapters for Radiation Therapy and Nuclear Medicine. With the increasing use of irradiation both pre and post operatively, the basic principles and clinical application of this modality should be included in a surgical text. Similarly, the use of radioactive isotopes have broadened both the diagnostic and therapeutic approaches for a surgical patient.

In addition to including material not usually found in a surgical text, the editors have organized the chapters somewhat differently from the usual text. Pertinent up to date references are found after individual sections of a chapter instead of the usual listing of all references at the end of the chapter. This convenience should be most helpful to the busy student and resident. Also, many sections in each chapter begin with the subheading of "Essentials of Diagnosis." Here the most important symptoms, physical findings and laboratory results of the disease process are summarized in a few lines. A typical example is found in the section on Obstruction of the Small Bowel:

- Colicky abdominal pain
- Anorexia; nausea and vomiting
- Obstipation
- Abdominal distention
- Peristaltic rushes
- Dilated small bowel on x-ray

For the student, this information should be most helpful, especially if he is dealing with the disease process for the first time.

I would consider this text most suitable for the busy student and resident.

Gerald T. Ujiki, M.D.

EKG

(Continued from page 616)

Answers: 1. C,D 2. E

The rhythm strip shows slight sinus arrhythmia which is non-respiratory. The abrupt changes in the R-R cycle length from 960 to 1000 milliseconds allow the appearance of the P wave. In other cycles, eg. 940 msec., the P wave is buried on top of the T wave of the preceding beat. The PR interval is markedly prolonged at 0.64 seconds. The long PR interval and the P wave on top of the T wave creates the false appearance of junctional rhythm and a long Q-T interval. Prolongation of the PR interval beyond 0.20 seconds or first degree AV block may be seen in all of the above clinical conditions. In the setting of acute myocardial infarction, the degree of PR lengthening is important prognostically. The cut off in importance statistically is a PR interval of 0.23 seconds.

A recent series of 89 patients with first degree AV block and acute myocardial infarction has been reported by A. B. Simon *et al* (*Chest* 62: 156-161, 1972). Thirty-one patients had a PR interval of 0.24 seconds or more and 42 per cent of these died. The remaining 58 patients had a PR interval of 0.23 seconds or less and a 19 per cent mortality. The severe PR interval prolongation in these cases seemed to reflect the severity of the underlying coronary artery disease. The longer PR interval patients progressed to complete heart block eight times as often as the shorter PR interval group. Our particular patient continued his uneventful hospital course and was discharged on the 17th hospital day.

COOK COUNTY

Graduate School of Medicine

CONTINUING EDUCATION COURSES
STARTING DATES—1976

REVIEW COURSE IN NEUROLOGICAL SURGERY, February 6
SPECIALTY REVIEW IN PEDIATRIC SURGERY, February 16
SPECIALTY REVIEW IN SURGERY, PART II, March 8
SPECIALTY REVIEW IN THORACIC SURGERY, February 23
BASIC ELECTROCARDIOGRAPHY, One Week, March 1
ADVANCES IN UROLOGY, Two Days, March 8
NEWER UROLOGIC INSTRUMENTATION, One Day, March 10
PEDIATRIC UROLOGY, Two Days, March 11
NEUROLOGY, BASIC, PART I, One Week, March 15
BASIC INTERNAL MEDICINE, One Week, March 15
NEUROPATHOLOGY, One Week, March 22
DIAGNOSIS & MANAGEMENT OF PROBLEMS IN GYNECOLOGY, March 22
SURGERY OF THE G. I. TRACT, One Week, April 5
SPECIALTY REVIEW PEDIATRIC CARDIOLOGY, Three Days, April 1
SPECIALTY REVIEW PEDIATRICS, One Week, April 5
DIAGNOSTIC RADIOLOGY, One Week, April 5
BLOOD VESSEL SURGERY, One Week, April 12

Information concerning numerous other continuation courses available upon request.

Address:
REGISTRAR, 707 South Wood Street,
Chicago, Illinois 60612

Doctor's News

OVERLAND CRITICAL CARE VAN GOES INTO SERVICE at St. Johns Hospital in Springfield. The OCCV will serve an 18 county area for intensive care transport of patients. The van contains resuscitation equipment, fluids, drugs, ventilators and radio units.

AMPAC APPROACHES FEDERAL ELECTION COMMISSION WITH PROPOSAL—The American Medical Political Action Committee has asked the Federal Election Commission to permit political groups to solicit support or endorsement of federal candidates through communications with members without having to subject such expenditures to the disclosure requirements of the law.

TREATMENT STUDY ON ANOREXIA NERVOSA SPONSORED BY NIMH.—This study is presently being conducted by the Research Department at ISPI. Patients aged 13-40 who satisfy the diagnosis of Anorexia Nervosa are being admitted. The patients will receive Psychotherapy, Periactin (Cyproheptadine), and Behavior Therapy in various combinations during an approximate stay of six weeks.

INCORPORATION OF AMA PROFESSIONAL LIABILITY REINSURANCE COMPANY authorized by the Board of Trustees. Before the company, to be known as the American Medical Assurance Co., can become operational, $1 million in capital and $1 million in surplus will be required as funding, and arrangements must be completed with state medical societies participating in the program. The purpose of the AMA company will be to provide increased capacity, added capital, and technical assistance to local society insurers writing primary professional liability insurance directly to physicians.

CALL FOR PAPERS FOR 6th ANNUAL CONFERENCE OF THE COUNCIL FOR CHILDREN WITH LEARNING DISABILITIES.—Any person or group wishing to present a paper or make some type of formal presentation at the 1976 Annaul I.C.C.L.D. Conference is invited to submit abstracts to the Program Committee. These contributions will be reviewed on the basis of quality, subject matter, relevance to the field of learning disabilities and special education, and overall appeal. The deadline for submissions of papers is December 1, 1975. For further information or to submit papers write: Mrs. W. Joseph Gartner, Program Chairman, 1976 I.C.C.L.D. Conference, 406 Hill Ave., Glen Ellyn 60137.

BIENNIAL MANUSCRIPT COMPETITION sponsored by the Obstetrics and Gynecology Specialty Group of the International College of Surgeons. This award is an invitation to the winning author to present his paper at the International Biennial Congress to be held in Athens, Greece, May 23-27, 1976. Round trip air fare, hotel expenses, and a diem are provided. For the rules of the competition write: Frank C. Lawler, M.D., Chairman Obstetrics and Gynecology Group, International College of Surgeons, United States, 1516 N. Lake Shore Dr., Chicago 60610.

CAN AN MD BE PROSECUTED AS A PUSHER? The U.S. Supreme Court may write new guidelines this term, on whether the government's bid to curb illicit drug traffic can override a physician's decision on what to prescribe. Oral arguments were scheduled in an appeal from a District of Columbia circuit court ruling that doctors registered to dispense controlled substances cannot be prosecuted as pushers even when, as in the particular case mentioned, the physician gave methadone to all comers who asked for it in whatever quantities they requested and based his bill on how much of the drug was prescribed. A few weeks after the D.C. decision, the U.S. Court of Appeals in Chicago came to the opposite conclusion—ruling that registration does not immunize a doctor from criminal drug prosecution.

IMPORTANT REMINDER TO PHYSICIANS FROM THE CHICAGO BOARD OF HEALTH

With the approaching colder weather it is again time to remind physicians (particularly those in the Chicago area) that the Rheumatic Fever Control Program, sponsored by the Chicago Board of Health, has available inexpensive throat culture services consisting of a mail-in-kit, laboratory processing and prompt reporting of positive cultures for Group AB Hemoloytic Strep.

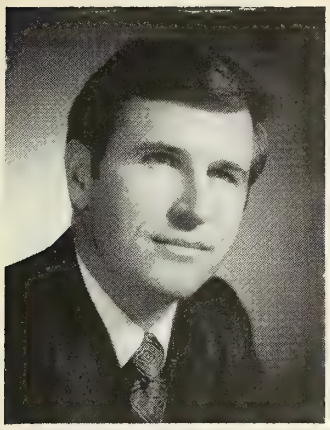
Since acute cases of Rheumatic Fever have a seasonal increase (starting in November), it is appropriate to stress that Rheumatic Fever is a reportable disease (312-744-4357) and every effort should be made to register new or newly found unregistered rheumatic patients in the Rheumatic Fever Registry. This is important for epidemiological and practical reasons. Rheumatic Fever prophylactic medication is available upon request to registered patients. Antibiotics for the prevention of Subacute Bacterial Endocarditis also can be obtained for your patient with Rheumatic Heart Disease.

For more information pertinent to the above, for registration, or for the ordering of kits, call or write to Rheumatic Fever Control Program, Miss Judith Bearfield, R.N., (Room LL-135), Chicago Board of Health, Civic Center, Chicago 60602. (312) 744-4284.

SOUTH PACIFIC ADVENTURE: The ISMS sponsored SOUTH PACIFIC ADVENTURE will depart from Chicago on March 1, 1976. This 14 day trip will include four days in Australia, 4 days in New Zealand, and four days in Tahiti, returning on March 14, 1976. A few additional seats are available. The price of the trip is only $1498. Contact P. L. Smithers or B. Duffy at Headquarters office for more details.

PHYSICIANS IN THE NEWS—Dr. Robert S. Mendelsohn, pediatrician and Assistant to the Executive Vice President at Michael Reese Hospital and Medical Center, has also been appointed Director of Development for Michael Reese. Recently elected President-Elect of the American Society of Oral Surgeons is **Daniel M. Laskin, M.D.,** chief of the advanced training program in oral surgery at the College of Dentistry, University of Illinois in Chicago.

Dr. Lawrence Hirsch has been elected as trustee from the 3rd District, filling the vacancy created by the resignation of Dr. Cloninger.



President's Page

Time for Change

The approach of a new year traditionally prompts the formulation of plans for change and a "new start." I believe this is an ideal time to talk about a much needed change and a "new start" in one area of medical education.

At this time there appears to be a resurgence of "concern for the individual" and a need for a more humanistic approach in the face of increasing medical technology and the application of this technology to the patient in a more personal, caring manner. Yet our medical education process seems locked into selecting individuals by criteria weighted excessively toward non-humanistic qualities and aptitudes. Obviously, items such as IQ, grade average and MCAT are numerical values which are easily compared. This explains their use in the selection process.

Admittedly, one cannot as easily quantitate devotion, compassion, concern, ethics, honesty, or commitment to service. But we must evaluate these traits if the more socially oriented, people-oriented, personality types are to be given an opportunity to enter medical school and learn the technological aspects of medicine. In this manner we may combine the two areas and train the physician that society will turn to, in the years ahead, as a dependable, stable, available, counselor for medical care.

The burden of restructuring admission criteria for medical schools falls on two groups:

- *Individuals involved in psychological testing.* These individuals long have maintained the validity of their tests conducted under sponsorship of government grants. They must rise to the occasion and provide mechanisms which will identify—prior to entry into medical school—students who meet the previously mentioned criteria. Granted, this is a difficult assignment, but, I believe, it is possible.
- *Committees involved in the selection process.* These groups—predominantly science and technology oriented—must accept responsibility for increased use of physchological evaluation mechanisms. In addition, the committees must become dedicated to changing the selection process and allowing admission of students who possess the qualities mentioned above. Also, they must provide mechanisms to insure an increased emphasis in the medical curriculum on the humanistic qualities of medical practice and patient orientation.

The physician of the future must be a resource who combines the humanistic, private and personal approach with tremendous life-saving technology.

J. M. Ingalls, M.D.

J. M. Ingalls, M.D.



membership forum

To the Editor,

The October, 1975 issue of *IMJ* carried a progress report on the Illinois Medichek program by Joyce Lashof, M.D., Director, Illinois Department of Public Health. In her report, Dr. Lashof states that 106,705 children had received Medichek services through March of 1975. Approximately 53,000 (one-half) of these children received medical exams and 53,000 children received dental exams.

The Will-Grundy County Medical Society has been involved in a work-study project of the Medichek program since July 1, 1974, in cooperation with ISMS, AMA and funded by DHEW. *Based on our understanding of Medichek procedure, we suspect this number to be inflated by duplication.* The total number is more likely to be considerably less than 106,000 since many children received both medical and dental screening exams, probably at the same location or on the same day.

We question whether the Illinois Medichek program is as successful as this report would indicate.

Albert W. Ray Jr., M.D.
President, Will Grundy County Medical Society

Reference Issue Addenda

In the October *IMJ*, in the Reference Section, the Committee on Committees was inadvertently listed as a Direct Reporting Committee and should have been as a Committee of the Board of Trustees.

In addition, an update of the section on the Society's Professional Liability Program is included below.

Professional Liability Program

The ISMS sponsored Professional Liability Program is underwritten and insured by The Hartford Casualty Company. It is administered by Johnson and Higgins. The program in its current form became effective on June 1, 1973. Now in its third policy period there are more than 6,000 physicians insured.

Society membership is a requirement for enrollment. Medical review committees in each ISMS district provide recommendations to the insurance company as an assist to underwriting and claims management.

The program covers physicians and surgeons for alleged malpractice claims arising from professional acts or omissions. Limits of $1 million, $2 million, $5 million or $100,000/$300,000 are available. Corporations and partnerships may be covered for an additional premium if each member is insured for a minimum of $1 million.

Optional personal excess liability protection is also available.

Applicants with a prior history of professional liability claims will be carefully reviewed before any commitment can be made.

To facilitate premium payments, a standard quarterly billing cycle has been established.

Full details and application forms may be obtained from ISMS.

A Quiz for Concerned Physicians

	Yes	No
1. Do you know the meaning of the following parts of the federal government's medical alphabet—and their far-reaching implications . . .? *NHI *HSA *PSRO		
2. Have you ever discussed medical issues with these non-medical "practitioners" of our profession . . .? *Your United States Senators *Your Congressman *Key Officials in the Department of Health, Education and Welfare		
3. Is the future of medicine important enough for you to take off a few days next January and get involved?		

* * * * * * * * * * * * *

Probably no Illinois physician can honestly answer yes to all the elements of question #1. A select few can answer yes to question #2, and hopefully many more will respond with a vigorous yes to question #3.

The times are too critical to sit back and let the other guy do it.

REGISTER TODAY
for the
1976 ISMS WASHINGTON ROUNDUP
January 25-28, 1976
L'Enfant Plaza Hotel, Washington, D.C.



Yes, Sign me up for the 1976 Washington Roundup.

Name _____ **Will Spouse attend?** _____

Address _____
Street City Zip

Office Phone _____ **Home Phone** _____
Area code Area code

Return completed form to:

Illinois State Medical Society
Governmental Affairs Division
55 East Monroe Street
Chicago, Illinois 60603

If you have any further questions, please write Bob Kjellander at the above address, or call him at 312-782-1654.

ILLINOIS HOUSESTAFF NEWS

Patient Care at Cook County Hospital

The "Housestaff News" is designed for interns and residents. News items and short articles of interest to housestaff will be considered for publication; materials should be sent to Michael Hughey, M.D., 711 Laurel Avenue, Wilmette, Ill. 60091.

While the news media has given considerable coverage of the recent strike by housestaff physicians at Cook County Hospital, little has been said about the many patient care issues raised by these housestaff physicians. Salary increases and limitation of working hours has played a small role in the demands of these physicians, and the Cook County Hospital Housestaff Association has chosen instead to emphasize patient care issues. A summary of these patient care issues is as follows:

1) Emergency Room
- —All rooms must be equipped for patient examination.
- —X-rays will be performed within 30 minutes.
- —CBC, electrolytes, glucose and urinalysis available within 30 minutes.
- —Blood gases ordered *Stat* available within 15 minutes.
- —Patient records available whenever needed.
- —Social service available 24 hours a day.

2) Admitting Area
- —IV and phlebotomy teams available.
- —A functional EKG machine and technician available.
- —Transportation service available.
- —Personnel available trained to insert NG tubes, Foley catheters, etc.

3) Wards
- —An examining room with equipment on each ward.
- —A light for each bed at night.
- —A laboratory available equipped with a microscope, centrifuge, phlebotomy equipment, and other equipment for performing urinalysis, CBC, gram stain, AFB, guiac.
- —An adequate number of nurses.
- —Ward clerks 24 hours a day.
- —IV and phlebotomy teams available.

4) Cardio-Pulmonary Resusitation
- —All housestaff should be trained in CPR.
- —Nursing staff should be trained in CPR.

5) Fantus Clinic
- —Patient records should be available.
- —X-rays ordered *Stat* should be done within one hour.
- —Routine X-rays should be performed within 2 weeks.
- —Laboratory requests should be performed the same day.
- —The pharmacy should be re-stocked daily.

6) In-patient X-ray Services
- —*Stat* studies should be performed within one hour.
- —Urgent requests should be performed within 24 hours.
- —Routine requests should be performed within 48 hours.
- —X-ray facilities should be staffed 24 hours a day.
- —CPR equipment should be available in procedure rooms.

7) Medical Records
- —Patient records should be available 24 hours a day.

8) Pharmacy
- —*Stat* orders should be filled within 30 minutes.
- —*Urgent* orders should be filled within 2 hours.
- —*Routine* orders should be filled within 12 hours.

9) Interpreters
- —Spanish interpreters should be available 24 hours a day.

10) OT, PT, ST
- —OT and ST available on weekdays.
- —PT available 7 days a week.

11) Inhalation Therapy
- —*Stat* orders carried out within 30 minutes.
- —*Routine* orders carried out the same day.

12) Laboratory Services
- —Routine tests should be drawn the morning after being ordered.
- —Results of these tests should be on the chart by 5:00 P.M. the same day.
- —*Stat* tests should be available within one hour plus the running time for that test.
- —CBC and differential should be available 24 hours a day.
- —Cardiac enzymes should be available 24 hours a day.

13) Out-of-title work
- —Out-of-title work should not be permitted on a routine basis.



PHYSICIAN opportunities

Oak Forest Hospital has senior physician openings. Consider the following in making your future plans:

- Accredited, 1800 bed long-term care facility: acute care, intensive rehabilitation unit, chronic disease hospital, intermediate care, outpatient services, community health network.
- Excellent opportunities in clinical medicine, teaching, research and administration.
- Opportunities for faculty positions in Chicago area medical schools for qualified applicants.
- Wide range of specialized and consultant services available at Oak Forest and its affiliate institution, Cook County Hospital.
- Inservice, seminar and convention attendance opportunities. Accredited by the Illinois Council on Continuing Medical Education.
- Competitive salary and benefit program.
- Malpractice coverage is made available without charge to the physician.

CURRENT VACANCIES:

- Staff Physicians
- Associate Chairman, Department of Geriatrics and Chronic Disease
- Chairman, Department of Community Medicine
- Chairman, Division of Orthopedic Surgery

Physicians interested in learning more about these opportunities by visiting the hospital with traveling expenses reimbursed, please contact:

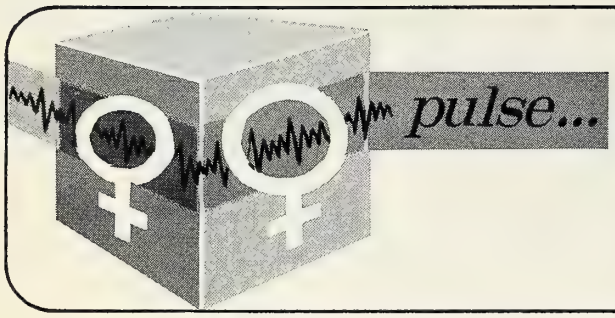
Herbert Notkin, M.D., M.P.H.
Medical Director

Telephone: (312) 928-4200, ext. 2202

Oak Forest Hospital

15900 S. Cicero Avenue Oak Forest, Illinois 60452

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pulse... of the doctor's wife

Mrs. Harold Keegan, Editor

Confluence for Health

We Americans talk about Health and we spend billions of dollars telling what is known about Health without the degree of success we hope for. It was the purpose of this conference to help the people of Illinois translate what is known into what people can feel and do about Health.

Too few people understand the relationship between personal behavior and health status. There are many problems to solve if an increase in the number of years of healthy and happy living is to become a reality for the people of America. To better understand health and health education, the Illinois State Medical Society and



Jane Ovitz, President-Elect, and Marcy Schwabenbauer, a participant in the "Confluence for Health."

Auxiliary co-sponsored a "Confluence for Health" conference on November 12th at the LaSalle Hotel, Chicago. At the conference the resources of medicine, education and the community came together to help promote the cooperation of individuals, groups, organizations and institutions for effective education for health.

The time is now for health education. Comprehensive school health education is developing, patient education is receiving more attention, and community health education is growing. Dr. Joseph Skom, Chicago, President-Elect, Illinois State Medical Society, told the conference about the many programs the society has to inform the public and to motivate them to improve their quality of life.

To be most effective in the schools, health education should be a well delineated and carefully organized program, with proper attention to the sequence and scope of instruction throughout the student's school years. For the student to grow into a healthy and mature individual he needs a program that has the proper concern for all aspects of personal, family and community health. The process should help the student develop desirable values for living and aid him in



Millie Vickery, Auxiliary President and Eunice Roller at "Confluence for Health."

making the best choices from possible alternatives. A panel of representatives from five universities that offer professional preparation for teaching health education expressed the desire to work cooperatively in meeting the health needs of communities and school age children in the state. Dr. Donald N. Boydston, Southern Illinois University, served as moderator and the panel members were: Thomas Janeway, M.P.H. Office of Superintendent of Illinois Public Schools; Dr. William Creswell, University of

Illinois; Dr. Eileen Harris, Southern Illinois University; Dr. Ann Nolte, Illinois State University; Carolyn Smith, Eastern Illinois University; and Dr. Robert Synovitz, Western Illinois University.

All citizens are urged to promote health education in the schools of Illinois through the implementation of the "Critical Health Problems and Comprehensive Health Education Act" that was passed by the 77th Illinois General Assembly and signed into law on August 31, 1971. Dr. Wallace Ann Wesley, Hs.D., Director, Department of Health Education, AMA, and Marcy Schwabenbauer, Coordinator of the Values Associates, Chicago, conducted a Valuing Workshop that gave the conference participants the experience of recognizing how their behavior is influenced by their knowledge, attitudes and practices. Everyone should remember that by your personal role in society, you are a health educator. Your behavior patterns are copied by those you are in contact with.

Dr. Eli Borkon, Southern Illinois University school of Medicine, stated we all must work together to educate our patients as well as our future doctors. New methods of teaching are used to bridge the gap between knowledge and application.

Through cooperative action of health care providers, educational systems and community-consumer citizens we can promote physical, mental, emotional, social and spiritual well-being. The conference closed with a Bicentennial thought that "the strength of America will continue to depend on the health of her people."

Participants:

William H. Creswell, Jr., Ed.D., Department of Health and Safety Education, University of Illinois, Champaign.

Dr. Ann Nolte, Department of Health Education, Illinois State University, Normal.

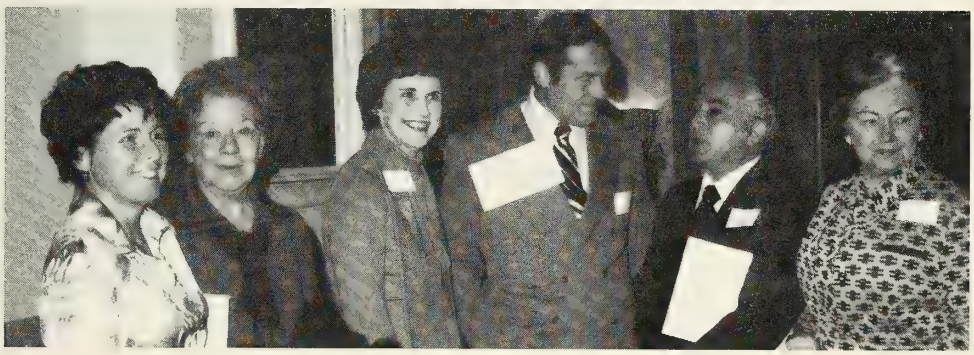
Mrs. Carolyn Ryle Smith, Assistant Professor, Health Education, Eastern Illinois University, Charleston.

Dr. Eileen Harris, Department of Health Education, Southern Illinois University, Carbondale.

Dr. Donald N. Boydston, Department of Health Education, Southern Illinois University, Carbondale.

Mr. Thomas M. Janeway, M.P.H., Office of Supt. of Illinois Public Schools, Springfield.

Dr. Robert Synovitz, Chairman, Department of Health Sciences, Western Illinois University, Macomb.



Another group at the "Confluence for Health": (left to right) Jane Ovitz, *President-Elect*, ISMS Auxiliary; Gladys Erickson, *President*, Illinois Women's Press Association; Millie Vickery, *President*, ISMS Auxiliary; Joseph Skom, M.D., *President-Elect*, ISMS; Eli L. Borkon, M.D., *1st Vice President*, ISMS, and Mrs. Borkon (Claire).



report

Illinois Society
American Association of Medical Assistants

An Open Letter to Physicians Concerning Their Office Assistants

Dear Doctor:

This letter enlists your help in acquainting physicians with the American Association of Medical Assistants.

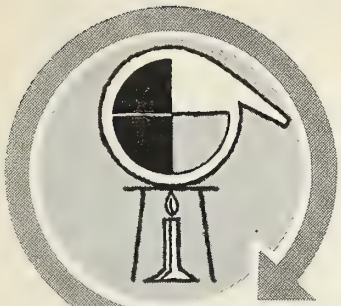
Primarily, this organization was formed to render honest, loyal and more efficient service to the medical profession and to the public which it serves. By charter, its constitution provides that *"it is not nor shall it ever become a trade union or collective bargaining agency."* The association is comprised of 48 constituent societies with a total membership of more than 16,000 members.

Since its inception nineteen years ago, AAMA has been commended on five different occasions by the American Medical Association's House of Delegates. Many AMA leaders have repeatedly praised the medical assistants' all-important role as a bridge between doctor and patient.

During its relatively brief history, AAMA has helped to increase the professionalism of its members. A national certification program has been developed to aid physicians in recognizing competent assistants in clinical, administrative and pediatric fields. AAMA, in collaboration with AMA's Council on Medical Education, also accredits medical assisting programs in post-secondary schools and colleges. Several days of educational programs are part of the AAMA annual convention. Numerous workshops and educational seminars are conducted by state societies throughout the year.

The American Association of Medical Assistants needs your support. If your assistants do not belong, why not encourage them to join? Members of this organization offer physicians loyalty, skill, service and adherence to high standards of professionalism which ultimately benefit their employers.

For information regarding membership please write to: Mrs. Velma Hukill, 2nd Vice President, c/o Coleman Clinic, Canton, Illinois 61520 or Mrs. Jean Nelson, 829 Carnaby Court, Schaumburg, Ill. 60172.



new pharmaceutical specialties

By Paul Dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

New Single Drugs—Drugs not previously known, including new salts.
Duplicate Single Drugs—Drugs marketed by more than one manufacturer.
Combination Products—Drugs consisting of two or more active ingredients.
New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

DUPLICATE SINGLE DRUGS

CENOCORT FORTE — Corticoid Rx

Manufacturer:	The Central Pharmacal Co.
Nonproprietary Name:	Triamcinolone Diacetate
Indications:	For i.m. administration in diseases responding to corticoid steroid therapy.
Dosage:	See package insert.
Supplied:	Suspension, vials 1 ml, multidose 5 ml; ml/40 mg.

DEXONE — Corticoid Rx

Manufacturer:	Rowell Laboratories, Inc.
Nonproprietary Name:	Dexamethasone
Indications:	Diseases responding to corticoid steroid therapy.
Dosage:	See package insert.
Supplied:	Tablets, 0.5; 1 and 2 mg.

KAY CIEL Elixir — Electrolyte Therapy Rx

Manufacturer:	Cooper Laboratories, Inc.
Indications:	Potassium deficiency states.
Contraindications:	Impaired renal function, untreated Addison's Disease, dehydration, heat cramps and hyperkalemia.
Dosage:	Adjust to requirement of each patient.
Supplied:	Elixir, 10%, 15 ml/1.5 g.

KOATE — Biological Rx

Manufacturer:	Cutter Laboratories, Inc.
Nonproprietary Name:	Antihemophilic Factor (Human)
Indications:	Classical hemophilia (hemophilia A)
Dosage:	See package insert.
Supplied:	Single dose bottles.

NEOCYTEN Inj. — Muscle Relaxant Rx

Manufacturer:	The Central Pharmacal Co.
Nonproprietary Name:	Orphenadrine Citrate
Indications:	To relieve pain in acute musculo-skeletal conditions.
Contraindications:	Those applying to anticholenergic drugs.
Dosage:	2 ml (60 mg) iv or im; may be repeated every 12 hrs.
Supplied:	Multi-dose, 10 ml; ml/30 mg.

SYNEMOL — Topical Steroid Rx

Manufacturer:	Syntex Laboratories, Inc.
Indications:	Inflammatory manifestations of corticosteroid-responsive dermatoses.
Dosage:	Apply 3 or 4 times daily.
Supplied:	Tubes, 15 and 60 g, cream 0.025%

COMBINATION PRODUCTS

CODIMAL — Cold Preparation o.t.c.

Manufacturer:	The Central Pharmacal Co.
Composition:	Each capsule contains:
	Chlorpheniramine Maleate 2 mg
	Pseudoephedrine HCl 30 mg
	Salicylamide 150 mg
	Acetaminophen 150 mg
Indications:	Temporary relief for symptoms of the common cold.
Dosage:	Adults: 1 capsule q.i.d.
	Children over 6 years: 1 capsule t.i.d.
Supplied:	Capsules

NORQUEN 21 day — Progesterone/Estrogen Comb. Rx

Manufacturer:	Syntex Laboratories, Inc.
Composition:	Each tablet contains:
	White Mestranol 0.08 mg
	Blue Mestranol 0.08 mg
	Norethindrone 2 mg
Indications:	Oral contraception
Contraindications:	See package insert.
Dosage:	1 white tablet daily from the 5th through the 18th day; 1 blue tablet daily at bedtime for 7 days, starting the 19th day.
Supplied:	Tablets

NOVAFED A — Nasal Decongestant o.t.c.

Manufacturer: Dow Pharmaceuticals

Composition: Each 5 ml contains:

Pseudoephedrine HCl	30 mg
Chlorpheniramine maleate	2 mg

Indications: Nasal congestion in acute upper respiratory disorders.

Dosage: Adults and children over 12 years: 2 teaspoonfuls every 4 hours.

Supplied: Liquid, 4 fl. oz.

NOVAHISTINE DMX — Cough Preparation Rx

Manufacturer: Dow Pharmaceuticals

Composition: 5 ml contains:

Dextromethorphan HBr	10 mg
Pseudoephedrine HBr	30 mg
Guaifensin	100 mg

Indications: Exhausting, nonproductive cough, accompanying respiratory tract congestion.

Contraindications: See package insert.

Dosage: Adults and older children, 2 teaspoonfuls three or four times daily.

Supplied: Bottles, 4 fl. oz.

RID-A-COL — Cold Preparation o.t.c.

Manufacturer: Ormont Chemical Company

Composition: Each tablet contains:

Chlorpheniramine Maleate	2 mg
Aspirin	390 mg
Caffeine	30 mg

Indications: Temporary symptomatic relief of colds.

Dosage: Initial—2 tablets; 1 tablet every 4 hrs, do not exceed 4 tablets daily.

Supplied: Tablets

RIFAMATE — Antitubercular Rx

Manufacturer: Dow Pharmaceuticals

Composition: Each capsule contains:

Rifampin	300 mg
Isoniazid	150 mg

Indications: Pulmonary tuberculosis

Warnings: Liver function tests prior to and during therapy should be carried out.

Dosage: See package insert.

Supplied: Capsules

NEW DOSAGE FORMS

KAY CIEL POWDER — Electrolyte Therapy Rx

Manufacturer: Cooper Laboratories, Inc.

Nonproprietary Name: Potassium Chloride

Indications: Potassium deficiencies

Dosage: One package in orange juice twice daily after meals.

Supplied: Packets, 1.5 gm. powder.

NOVAFED Liquid — Nasal Decongestant o.t.c.

Manufacturer: Dow Pharmaceuticals

Nonproprietary Name: Pseudoephedrine HCl

Indications: Nasal congestion in acute upper respiratory disorders.

Dosage: Adults and children over 12 years, 2 teaspoonfuls, not to exceed 4 doses in 24 hrs.

Supplied: Liquid, 4 fl. oz., 5 ml/30 mg.

★

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A Small Community Blood Bank Frozen Blood Program

Twelve Month Report

By Richard D. Crowley, Ex Dir./Springfield

The Central Illinois Community Blood Bank, located in Springfield, meets the total blood needs of three hospitals. The blood bank has a 100% volunteer donor roll, and collected 10,086 units of blood during the year. It received no blood from Clearinghouse or any other source. The blood bank was founded in 1971, and drew blood from its first donor on November 16, of that year. Prior to that time the two hospitals of Springfield operated their own donor programs, and the hospital in Jacksonville was supplied most of its needs through the Red Cross program in St. Louis, Mo., 100 miles south.

Blood Needs

Memorial Medical Center of Springfield, is a 600 bed private hospital. The renal unit and transplant service administer to approximately 60 patients. The blood needs of these 60 patients came to about 400 units of leukocyte poor blood in 1973. The Community Blood Center had an IEC PR-6 refrigerated centrifuge, which was used to prepare leukocyte poor units from freshly drawn bloods by inverted centrifugation. The closest available frozen blood at that time was in Chicago, 200 miles north. The total blood needs of Memorial exceed 3,000 units of blood, and 500 units of components per year.

Saint John's Hospital of Springfield is somewhat larger then Memorial, and while it does not operate a renal program, it does have over 300 open heart procedures a year. The total blood needs of Saint John's exceed 5,000 units a year of blood, and 500 units of components.

Passavant Memorial Hospital of Jacksonville, is a 250 bed hospital located about 30 miles west of Springfield. It has a total blood need of just over 1,000 units a year.

The decision to provide frozen blood to the three hospitals was made final in November, 1973, and a Haemonetics model 15 cell washer was purchased. Prior to this decision we visited two blood banks that provided frozen blood. In addition, we made a number of phone calls to people experienced in frozen blood, researched all the literature we could find, and spent time with representatives of Fenwal, IBM and Haemonetics. Most of the motivation for us to provide frozen blood came from the needs of the renal unit. The total need of the unit was relatively small, but we felt the *individual need of each patient* was as great here in Springfield as it was in any other community.

Cost of Mechanical Freeze Procedures

The main reason we hesitated to provide the frozen service was what we were told about the high cost to capitalize such a program. There seemed to be general agreement around the country that we would need almost $25,000, if not more. It was also indicated that our per unit cost would exceed $75, and with our low volume, would no doubt approach, if not exceed, $100.

We actually spent less than $10,000 to capitalize the project and purchase the needed solutions and disposables for the first 50 units of frozen red cells. Our actual per unit cost is well under $60.

It was also indicated to us that a small center would lack the technical capability to provide frozen blood. This is completely false. The technical methodology for frozen blood is far more simple than most of the other procedures performed in our laboratory.

A final concern to me was the possibility that excessive outdating could be expected in working with a unit of blood that had but a 24 hour shelf life, once removed from the freezer. My concern with outdating is primarily financial. Others may have medical, technical or even social concerns, but my job is to pay the bills, and an outdated unit provides no revenue to the Community Blood Center. Our blood center has

RICHARD D. CROWLEY has served as an Executive Director of the Central Illinois Community Hospital in Springfield since 1971.

always assumed complete financial responsibility for outdating, and I was anxious to continue this, even with 24 hour blood. In the first six months of our program, we provided 238 units of frozen red cells and 6 of them were not transfused. That is about the same percentage of red cells outdating in our overall program.

Cost Saving Factor

Before going into the details of setting up our program, I would like to point out what I feel is a significant cost saving factor in frozen blood for renal patients.

Our policy, prior to frozen blood, was to accept stat orders for leukocyte poor blood 24 hours a day, seven days a week, every week of the year. Our blood center is open 60 hours a week, so there were times when we opened the blood center just to provide the leukocyte poor units. It's true we had management procedures that made it possible for us to provide the total service and rarely get called back, but still it did happen.

All leukocyte poor units were prepared from freshly drawn units of type specific blood by use of the inverted centrifugation procedure outlined in the AABB Component Therapy Manual. When the orders for leukocyte poor blood came in, they required the undivided attention of one of the medical technologists. A nurse or myself were able to assist, when the situation required it, but leukocyte poor blood, with that procedure, always required the full attention of at least one person. It also quite often caused us to use blood that we had other plans for, since we collect blood on a need basis. Blood drawn for the open heart, might be needed in the renal program. Then other donors would have to be called for the open heart.

The use of leukocyte poor frozen red cells has greatly reduced the manpower problem and has completely eliminated our having to use blood originally drawn for some other purpose. We stockpile between 85 and 100 units in the freezer. Our basic freezer inventory is:

25 O Positive	15 O Negative
25 A Positive	15 A Negative
8 B Positive	3 B Negative
2 AB Positive	2 AB Negative

In addition to the ABO and Rh type, we are checking most of these units for C and E, as well as some cases of little c. We also check and record for Kell, Duffy, and Lewis, and on occasion other sub groups such as A2. All frozen blood is given type specific.

Advantages

In our frozen blood program, the medical technologists inform our nurses each time a unit is removed from the freezer. The nurses then add a type specific donor to the calling list for the day, whenever our schedule permits. The blood for the freezer is drawn in a Fenwal Triple, and the technologists freeze it, as their time permits. In addition to saving us money in man hours, this method has removed a source of tension among the staff, when unexpected orders create headaches. This cannot be overlooked when discussing the advantages of frozen blood. It may not be a clinical advantage but it certainly is anything but a minor convenience.

Another unexpected bonus for us concerned a chronic blood user at Passavant Hospital in Jacksonville. The patient is B Positive, Big C negative and has received over 300 units of blood in the last five years. He has been sensitized to Big C and suffered reactions that were pretty well pinpointed as white cell related. The normal routine was for the patient to get two or three units, every two to three weeks. Because of his transfusion reactions he was being transfused with leukocyte poor blood, and because of the Big C, we found it easier to use B Negative blood. The problem was complicated by the fact that Jacksonville is 30 miles away, and we only have two busses a day going that way. Because of this situation we were over-using our B Negative donors and were working against the clock and bus schedule. The patient was having reactions with almost every transfusion, even though special procedures were followed.

In June of 1974 the patient was transfused with his first units of frozen blood. He had no adverse reaction to the transfusions. Through December, 1974, the patient has received a total of 48 units of red cells. We no longer give him B Negative. Each time a B Positive donor comes to the blood center he is checked for C and E. If the Big C is negative we freeze that unit, and put it aside for Jacksonville. This has greatly reduced the strain on our B Negative list, as well as provided a much more comfortable transfusion for a man who had had more than his share of discomfort.

Why Mechanical Freeze?

Why did we go to the mechanical freeze over liquid nitrogen? One center we visited was using liquid nitrogen, and another was using the Harris freezer. The main advantage liquid nitrogen seemed to offer was the lack of concern over

power failures. An auxiliary power plant in the blood center would solve that problem, so I could see no advantage to it. An extended power outage at the blood center would create so many problems, that my concern for the frozen blood would be but one of a dozen things to worry about.

There seemed, to be a number of disadvantages to the use of liquid nitrogen, including the possible unavailability of the material. It would have to come from Chicago, 200 miles to the north. While transportation is not usually a problem in Illinois, there are time when weather slows everything down, as well as the possibility of labor strikes, shortage of the liquid nitrogen, the on going cost of buying it, the added room requirements of storing it, and the possible danger to the staff of working with so cold a material.

Since we could find no literature giving specific advantages to the use of the liquid nitrogen, as it concerned the quality of the unit of frozen cells, we decided on the mechanical freezer. One year later I am satisfied we made the right decision. Not only to the method of freezing, but to our selection of the Harris unit. It has a capacity of over 200 units, and since we stockpile only a 100 units, inventory control (first in-first out) has been no problem. The technologist can locate the desired unit in less than 15 seconds, so the freezer is opened very little. We had one problem with a leak in one of the compressors, but it was fixed immediately by the manufacturer at no cost to the blood center. Even with the leak, the freezer maintained the required temperature, so it was no real problem. We ordered the freezer in November, 1973. Four weeks later it was in the blood center.

The cost of the freezer, delivered and installed, was under $4,000. It has added some to our utility bill, but it is an insignificant amount. The bill varies every month, and I have not found it worthwhile to try and determine the amount of increase related to the freezer.

What Washing Procedure?

Which washing procedure to use was a more difficult decision to make. There were at least four systems on the market and the proponents of each system had a multitude of reasons for using their system. We found nothing to prove that any of the systems produced a higher quality unit of washed cells. No salesman made such a claim and no blood banker made such a claim. There was no literature on this subject either. Based on these circumstances, we proceeded to examine the operational and financial aspects of each of the systems. The final decision was based almost entirely on two factors: *Low cost and simplicity of operation.*

We decided our capitalization program would include the costs involved in the first 50 units of blood to be frozen. Our estimates for the cost to capitalize the various systems were:

(1) IBM At least $20,000.00
(2) Fenwal At least $12,000.00
(3) Haemonetics .No more than $4,000.00

We didn't look at any other systems.

Most of the cost with the IBM was in the cost of the cell washer. As I recall, it came to about $18,500. There would be no installation costs, training requirements were minimal, and the machine was already located in Springfield, so time delay would be zero.

The cost to set up the Fenwal system would include, for us, the purchase of a Sorval refrigerated centrifuge, since the only one we had was an IEC PR-6. There would also be installation requirements, since the equipment would require 220 volts ac. The space requirements for the Elutramatic and the refrigerated centrifuge were about triple that of the IBM and the Haemonetics. I called Sorval and was told it would take about six to eight weeks, after a credit check, before I could expect the centrifuge. The Fenwal representatives told me they could get one quicker, and they estimated it would be less than a month from the time I placed the order until we set up. They would have a representative on the scene to supervise installation and training of our staff.

The cost in setting up the Haemonetics was divided almost evenly between the price of the model 15 cell washer and the disposables for the first 50 units. The model 15 at that time sold for $2,264. The 50 bowls, washing harness and waste bags came to about $1,500. It took less than two weeks from the time I ordered the model 15 until it arrived. Less than one hour after it arrived, it was in use at the blood center.

In addition to the $4,000 for the model 15 and plastic disposables, we spent about $600 on the needed solutions for freezing and washing our first 50 units of blood.

Total cost to set up the entire procedure:

Freezer	4,000.00
Washer	2,364.00
Disposable	2,000.00
Other	1,000.00

Total Spent: $9,364.00

The procurement cost figures for these three systems show without question that Haemonetics is by far the most economical system to install. My main financial problem was capitalization. Once the program was set up, the charges to the patient would be based on per unit cost.

Simplicity of Operation

The second factor in our purchase decision was simplicity of operation and upkeep on the equipment. The Haemonetics model 15 has a three quarter horsepower motor that drives a fixed speed centrifuge at 4400 rpms. There is only one switch, the on & off control. The machine has no complicated electronic circuits, photoelectric cells, dials or pumps. It can be fixed by any electrician. In 12 months of operation, the model 15 has not been broken once. All units of frozen blood ordered, have been supplied. Our biggest single order, 12 units for one patient, was prepared for use in surgery in less than 8 hours. We were so satisfied with the model 15 in our frozen blood program, that after three months we ordered a second model 15. There are three advantages in having the second model 15:

1. It is a back up if one machine breaks down.
2. It enables us to provide washed blood for two patients at one time.
3. It allows us to produce 4 units for one patient in less than one hour.

One technologist can handle both machines at the same time, wash 2 units in one hour on each machine and if need be, continue at this rate throughout a full 8 hour shift. If necessary, we are sure that with the two cell washers, one technologist could provide 30 units of washed cells in a working day. It is true our volume to date, has been relatively small. We have washed 400 units in the first 12 months. However, we feel the machine would continue to work as well even if our volume were to triple.

Operational instructions are also simple. A technologist who has used the machine could show any one how to set up the harness, turn on the equipment, turn off the equipment and transfer the finished unit from the bowl to the transfer pack, *in less than 5 minutes.*

Summary

Simplicity of operation and installation, as well as low procurement cost are the factors that helped us make our final decision. We were prepared for a somewhat higher per unit cost, however, after producing about 100 units, we determined that our total per unit cost was under $60.00. I know there are those who will argue this per unit cost figure. My figures are based on providing 2 units of washed cells from one bowl, with one washing harness and two waste bags. If the order is for one unit, the cost rises about $15.00. It is cheaper to provide two or more units at a time for each patient. Our quality control program, based on the first 50 units frozen, determined that it was safe and practical to use the bowl twice, and even more, if the blood was to be used on the same day, for the same patient. Most orders that come in, are for two or more units, *so the per unit cost to provide a single unit is not relevant.*

Per unit cost breakdown:
(Based on 2 units per bowl)

Washing bowl (at our purchase volume)	$10.00
Washing Harness	2.38
Waste Bag	.74
TA 20 (Fenwal) freeze bag	2.17
TA 1 (Fenwal) final bag	1.35
Storage carton (during freeze)	.16
12% sodium chloride (Fenwal)	.85
0.2% dextrose, etc.	2.10
1.6% sodium chloride	1.74
Glycerin, etc.	1.50
Misc. (delivery, labels, etc.)	.50
Total of items above: $23.49	
Technology Time (pro-rated for one unit from pre-freeze through final wash)	$ 3.00
Per unit to collect and process one unit of donor blood (1973 audit)	$24.85
Depreciation	$ 4.00
Total per unit cost (all of the above)	$55.34

Our total charge to the patient is $60.00. This allows for a 7% discard of units collected for the frozen blood program, which for one reason or other, are not transfused. ◄

Note: Crossmatching and infusion of the unit are done at the hospital. There are normal crossmatch and infusion fees. These fees are not related to the blood program, nor are they any different for frozen blood than they would be for whole blood or packed cells. These charges are directly related to the cost to the hospital in providing the patient with infusion of a compatible unit of blood. This paper deals only with the cost to the blood center and the revenue it receives from each unit of transfused frozen red cells.

YOU'LL HAVE TO SPEAK UP

By

RICHARD L. LESHER
President
Chamber of Commerce
of the United States



Everybody agrees that the worker should be protected from dangerous noise levels. But that's where the agreement ends.

Some experts believe the upper noise limit should be 90 decibels (dBA). That's about as noisy as a busy New York subway station.

Other experts believe 90 dBA is too high, and want the standard to be 85 dBA, which is about the noise level of a busy street corner.

Much more important than the level, however, is how it is to be reached.

The simplest, least expensive and most effective way of protecting a worker's hearing from a noisy environment is to equip him with a set of custom fitted ear plugs or ear muffs (which look like hi-fi headphones without a cord).

The alternative is to redesign all machinery to make it quieter in operation.

Labor and nearly all of the federal agencies involved want industry to try redesign first, to the extent "feasible," and to resort to ear plugs only if redesign fails.

Representatives of industry say it doesn't make much sense to choose the most expensive possible solution—redesign—when there's a better way to do it that costs far less.

How much less? Personal ear protection for all who need it would cost about $23 million. Modifying or replacing present factory equipment to meet the proposed noise standards—if it could be done at all—could cost up to $150 billion. Even OSHA puts the cost as high as $31 billion (in 1973 dollars).

Why *not* use ear plugs? Well, say labor representatives, they might be uncomfortable and workers might not wear them. But, hardhats, safety glasses and safety shoes are also a nuisance, and yet workers are willing to wear them for their own good.

And it does seem strange, when you think about it, that the same Federal Government that doesn't consider three-point auto safety belts too great an inconvenience for the motorist is nevertheless willing to spend $150 billion of our money to save some factory workers from ear plugs.

If you agree, call your congressman and give him an earful.

MANUSCRIPT INFORMATION

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed.

Manuscripts should be typed, double spaced, and submitted in duplicate, one original and one carbon. An article should not exceed **12 to 16 manuscript pages,** (including illustrations) and should be briefer if possible. Please enclose personal glossy photos of author or authors. Snapshots are not suitable for reproduction.

References should be numbered in order of appearance in the text and conform to the following style in the order given: name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Make drawings and charts in black ink. If photographs are submitted, send black and white glossies. Number illustrations consecutively and indicate their place in the text. Number, indicate the top and place the author's name on the back of each illustration.

Address manuscripts to:

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ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
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Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

January, 1976

Chest Diseases

MANAGEMENT OF TUBERCULOSIS IN GENERAL HOSPITALS
For: All specialties. Symposium. **Speaker:** Thomas J. Pozen, M.D., Director, DuPage County TB Clinic. Jan. 21, 2:00 PM-5:00 PM. Elmhurst Country Club, Wood Dale. **CME Credit:** 3 hrs. AMA Cat. 1, AAFP Elective. **Sponsor, contact:** DuPage County Medical Society, 646 Roosevelt Rd., Glen Ellyn, IL 60137.

Dermatology

SOME CUTANEOUS CLUES TO SIGNIFICANT DISEASES
For: All physicians. Lecture. Jan. 14. Chicago. **Speaker:** J. Hasegawa, MD, Chief, Section of Dermatology, VA Research Hospital. **CME Credit:** 1 hr. AMA Cat. 1, AAFP. **Fee:** None. **Sponsor, contact:** Martha Washington Hosp., 4055 N. Western Ave., Chicago 60618. Attn: Ralph Gradman, M.D.

Endocrinology

FUNCTIONING AND NON-FUNCTIONING TUMORS OF THE PITUITARY
For: All physicians. Lecture. Jan. 20, 1976, 8:00 PM. Highland Park Hospital. **Speaker:** Raymond V. Randall, M.D., Mayo Clinic. **Reg. Limit:** 70. **Reg. Deadline:** Jan. 15. **Sponsor, contact:** Highland Park Hospital, 718 Glenview Ave., Highland Park, IL 60035. Att'n: Mrs. Susan Struttle, Admin. Secy.

Family Medicine

IMMUNO-DEFICIENCY DISEASES
For: All physicians. Group Discussions and Lecture. Jan. 9, 10 AM, Bethesda Hospital; Jan. 9, 6 PM, Lincolnwood Hyatt House; Jan. 10, 10 AM, S. R. Forkosh Hospital. **Speaker:** Dr. John Clough, Cleveland Clinic. **CME Credit:** 5 hrs. AMA Cat. 1. **Fee:** $10 (other than staff for dinner). **Reg. Deadline:** Dec. 29 (dinner only). **Sponsor:** FAB³/CME. **Contact:** Bethesda Hospital, 2451 W. Howard St., Chicago 60645. Attn: Mr. Neil Glass.

Family Medicine

IMMUNOLOGY IN CLINICAL PRACTICE
For: Physicians. Lecture. Jan. 20. 8:00 PM. Sherman Hosp. **Speaker:** John Robinson, M.D., Loyola Medical Center. **CME Credit:** 2 hrs. AMA Cat. 1. **Fee:** None. **Sponsor, contact:** CME Committee of Sherman Hospital, 934 Center St., Elgin, IL 60120. Attn: Walter E. Gasser, M.D., Chairman.

General Surgery Trauma

CLINICAL HOSPITAL PROGRAM ON GENERAL SURGERY TRAUMA
For: All Physicians, Residents, Interns. 2-hour Evening Clinical Program. Jan. 20. Resurrection Hospital, Chgo. **CME Credit:** 2 hrs. AMA Cat. 1; AAFP. **Sponsor, contact:** Chicago Committee on Trauma of the Amer. College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. Attn: Mrs. Lillian Husa, Exec. Sec.

Internal Medicine

THE YEAR OF INTERNAL MEDICINE 1976
For: All MD's. Post-Graduate Short Course. Jan. 21, 8 AM-5:15 PM; Jan. 22, 9 AM-5:15 PM; Jan. 23, 9 AM-5:15 PM. Northwestern University Medical School, Offield Auditorium. **CME Credit:** 21 hrs. AMA Cat. 1, AAFP Elective. **Fee:** $125. **Reg. Limit:** 110. **Sponsor, contact:** Northwestern University Medical School, Clinical Training Division, Post-Graduate Education, 303 E. Chicago Ave., Chicago 60611. Attn: Jacob Suker, M.D., Assoc. Dean, Grad. Med. Educ.

Medical Education

SYMPOSIUM ON CONTINUING MEDICAL EDUCATION
For: All MD's. Symposium. Jan. 28. 9:30 AM-Noon. Robert C. Hartmann Sr. Auditorium, Chicago. **Speakers:** Kenneth Furlong, M.D., Thomas C. Meyer, M.D. and Leonard Stein, Ph.D., **CME Credit:** 2 hrs. AMA Cat. 1. **Fee:** None. **Sponsor, contact:** Martha Washington Hospital, 4055 N. Western Ave., Chicago 60618. Attn: Ralph Gradman, M.D.

Medicine

GENERAL MEDICINE LECTURE SERIES
For: Attending and House Staff. Lecture Series. Every Tuesday 11 AM. St. Mary of Nazareth Hosp. Center. **CME Credit:** 1½ hrs. AMA Cat. 1, AAFP Elective. **Fee:** None. **Reg. Limit:** 50. **Sponsor, contact:** Saint Mary of Nazareth Hospital Center, 2233 W. Division St., Chicago 60622. Attn: Anthony Sapienza, M.D., Dir. of Med. Educ.

Obstetrics, Gynecology & Pediatrics

SIXTH SEMINAR ON SURGERY AND MEDICINE
For: Medical Professionals. Lecture. Jan. 28, 8 AM-Noon. St. Therese Hosp., Waukegan. **CME Credit:** 4 hrs. AMA Cat. 1. **Fee:** None. **Reg. Deadline:** Jan. 26. **Co-sponsor:** University of Health Sciences/The Chicago Medical School. **Sponsor, contact:** St. Therese Hospital, 2615 W. Washington, Waukegan, IL 60085. Attn: R. M. Adelman, D.D.S., M.D., Vice President/ Medical Affairs.

Orthopedics

FOOT PROBLEMS OF THE NEWBORN
For: Pediatricians. Monthly dinner meeting/lecture. Jan. 20. 8:00 PM. Holiday Inn, Chgo. **Sponsor, contact:** Chicago Pediatric Society, 2800 W. 87th St., Chicago, IL 60652. Attn: Thomas Driscoll, M.D. (for dinner reservations).

Pulmonary

ACUTE RESPIRATORY DISTRESS SYNDROME
For: Physicians, nurses, para-medics, students. Weekly Seminar. Jan. 6. Memorial Hospital of DuPage County, Elmhurst. **CME Credit:** 1 hr. AMA Cat. 1. **Fee:** None. **Co-sponsor:** Upjohn Co. **Sponsor, contact:** Memorial Hospital of DuPage County, Avon & Schiller St., Elmhurst, IL 60126. Attn: John Huss, M.D. Dir. of Med. Educ.

Psychiatry

EMPTINESS IN THE LIVES OF COMEDIANS
For: Physicians, Mental Health Professionals. Lecture. Jan. 7. 7:30-9:30 PM. Des Plaines. **Speaker:** Samuel S. Janus, Ph.D., NY Medical College. **CME Credit:** 2 Hrs. AMA Cat. 1, AAFP Elective. **Fee:** $15 (ind. lectures). **Reg. Limit:** 120. **Co-sponsors:** Chicago Medical School, Dept. of Psychiatry and Forest Hospital Foundation. **Contact:** Forest Hospital, 555 Wilson Lane, Des Plaines, IL 60016.

THE KEY CONFERENCE AND THE FUTURE OF THE AMERICAN PSYCHIATRIC ASSOCIATION
For: Psychiatrists. Lecture. Jan. 21. 8:00 PM. Passavant Hosp., Chicago. **Speaker:** Melvin Sabsin, M.D., American Psychiatric Association. **CME Credit:** 1½ Hrs. AMA Cat. 1. **Sponsor, contact:** Institute of Psychiatry, Northwestern U. Med. School, 320 E. Huron St., Chicago 60611.

Psychotherapy

THE RATIONAL THERAPY APPROACH TO CRISIS COUNSELING IN MEDICAL OR LEGAL SETTINGS
For: Mental Health Treatment Professionals. Symposium. Jan. 21. 1:00-4:00 PM. Riveredge Hospital, Forest Park. **Speaker,** Virginia Anne Church, J.D., Ph.D., Dean, Lewis Univ. College of Law. **Fee:** $10.00. **Reg. Limit:** 204. **Reg. Deadline:** Reservations Req. **Sponsor, contact:** Riveredge Hospital Foundation, 8311 W. Roosevelt Rd., Forest Park, IL 60130. Attn: John Pontarelli, Community Relations Coordinator.

Surgery

TOTAL INTRAVENOUS NUTRITION
For: Physicians, nurses, para-medics, students. Weekly Seminar. Jan. 20. Memorial Hosp. of DuPage County, Elmhurst. **CME Credit:** 1 hr. AMA Cat. 1. **Fee:** None. **Sponsor, contact:** Memorial Hosp. of DuPage County, Avon & Schiller, Elmhurst, IL 60126. Attn: John Huss, M.D., Dir. of Med. Educ.

Trauma

TREATMENT OF TRAUMATIC INJURIES OF THE HEAD
For: Physicians, nurses, para-medics, students. Weekly seminar. Jan. 27. Memorial Hosp. of DuPage County, Elmhurst. **CME Credit:** 1 hr. CME Cat. 1. **Fee:** None. **Sponsor, contact:** Memorial Hosp. of DuPage County, Avon & Schiller, Elmhurst, IL 60126. Attn: John Huss, M.D., Dir. of Med. Educ.

February, 1976

Chest Disease

LUNG CANCER
For: All MDs. Lecture. Feb. 11. 2:00-5:00 PM, Univ. of Chicago Hosp. & Clinics. **Speaker:** Nicholas J. Gross, MD., Ph.D., Asst. Prof. Dept of Med. **CME Credit:** 3 hrs. AMA Cat. 1; AAFP Elective. **Fee:** $20. **Reg. Limit:** 250. **Sponsor, contact:** Univ. of Chicago, Frontiers of Medicine, 950 E. 59th St., Box 451, Chicago, IL 60637.

SPECIALTY REVIEW COURSE IN THORACIC SURGERY
For: Thoracic Surgeons. 5-day course. Feb. 23-27. **CME Credit:** 40 hrs. AMA Cat. 1. **Reg. Limit:** 200. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612.

Family Medicine

HEAD START—10 YEARS LATER
For: All MD's Group Discussions, lecture. Feb. 11, 10 AM, Forkosh Hosp.; Feb. 11, 6 PM, Lincolnwood Hyatt House; Feb. 12, 10 AM, Bethany Methodist. **Speaker:** Dr. Julius Richmond, Harvard Medical School. **CME Credit:** 5 hrs. AMA Cat. 1. **Reg. Deadline:** Feb. 6 (dinner only). **Sponsor:** FAB³/CME. **Contact:** S. R. Forkosh Memorial Hosp., 2544 W. Montrose, IL 60618. Attn: Mr. S. Plotner.

Family Medicine

CHEMOTHERAPY IN COLON CANCER
For: Physicians. Lecture. Feb. 17. 8:00 PM. Sherman Hosp., Elgin. **Speaker:** Allan J. Schutt, M.D., Mayo Clinic. **CME Credit:** 2 hrs. AMA Cat. 1. **Sponsor, contact:** CME Committee of Sherman Hospital, 934 Center St., Elgin, IL 60120. Attn: Walter E. Gasser, M.D., Chairman.

Medicine

GENERAL MEDICINE LECTURE SERIES
For: Attending and House Staff. Lecture Series. Every Tuesday 11 AM. St. Mary of Nazareth Hosp. Center. **CME Credit:** 1½ hrs. AMA Cat. 1, AAFP Elective. **Fee:** None. **Reg. Limit:** 50. **Sponsor, contact:** St. Mary of Nazareth Hosp. Center, 2233 W. Division St., Chicago 60622. Attn: Anthony Sapienza, MD, Dir. of Med. Educ.

Medicine and Surgery

AMERICAN SOCIETY OF CONTEMPORARY MEDICINE AND SURGERY
For: All Physicians. Lectures, small group & individual conferences, workshop. Feb. 1-6. 8:00-6:00 PM. Chicago. **CME Credit:** AMA Cat. 1. **Sponsor, contact:** American Society of Contemporary Medicine & Surgery, 30 N. Michigan, Chicago, IL. Attn: John Bellow, M.D., Director.

Medicine and Surgery

CONTEMPORARY MEDICINE AND SURGERY
For: Practicing Physicians. Annual meeting and scientific assembly. Feb. 29-March 5. **Speaker:** Leon O. Jacobson, M.D., Dean, U of Chicago Medical School. **CME Credit:** 40 hrs. AMA Cat. 1; 30 hrs. AAFP Elective. **Fee:** $150-Members; $225-Non-members. **Reg. Deadline:** Feb. 15. **Sponsor, contact:** American Society of Contemporary Medicine & Surgery, 30 N. Michigan, Rm. 1506, Chicago, IL 60602. Attn: John Bellows, M.D., Ph.D.

Musculoskeletal and General Surgery Trauma

CLINICAL HOSPITAL PROGRAM ON MUSCULOSKELETAL AND GENERAL SURGERY TRAUMA
For: All physicians, residents, and interns. 2-hour Evening Clinical Program. Feb. 17. Loyola Univ. Med. Center, Maywood. **CME Credit:** 2 hrs. AMA Cat. 1; AAFP. **Sponsor, contact:** Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. Attn: Mrs. Lillian Husa, Exec. Sec.

Neurology

REVIEW COURSE IN NEUROLOGICAL SURGERY
For: Neurologists. 10-day course. Feb. 6-15. Chicago. **CME Credit:** 95 hrs. AMA Cat. 1. **Fee:** $400. **Reg. Limit:** 200. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612.

Pathology

PATHOLOGY OF TUMORS OF THE LUNG
For: All MD's. Lecture. Feb. 25. Robert C. Hartmann, Sr. Auditorium, Chicago. **Speaker:** Hector Battifora, M.D., Northwestern Univ. Med. School. **CME Credit:** 1 hr. AMA Cat. 1, AAFP. **Co-Sponsor:** American Cancer Society. **Sponsor, contact:** Martha Washington Hosp., 4055 N. Western Ave., Chicago, IL 60018. Attn: Ralph Gradman, M.D.

Pediatrics

MEDICAL-LEGAL PROBLEMS OF PEDIATRICS
For: Pediatricians. Monthly dinner meeting/lecture. Feb. 17. 8:00 PM. Holiday Inn, Chicago. **Speaker:** Philip Corboy, Attorney at Law. **Sponsor, contact:** Chicago Pediatric Society, 2800 W. 87th St., Chicago 60652. Attn: Thomas Driscoll, M.D. (for dinner reservations).

Psychiatry

INDIAN MEDICINE—EAST & WEST
For: Physicians, Mental Health Professionals. Lecture series. Feb. 4. 7:30-9:30 PM. Des Plaines. **Speaker:** Robert Bergman, M.D., Director Psychiatric Residency Program. **CME Credit:** 2 hrs AMA Cat. 1; AAFP Elective. **Fee:** $90 (entire series); $15 (indiv. lectures). **Reg. Limit:** 120. **Sponsor, contact:** Forest Hospital Foundation, 555 Wilson Lane, Des Plaines, IL 60016. Attn: June Bengsten. **Co-sponsor:** Chgo Medical School, Dept. of Psychiatry.

ACCOUNTABILITY TO WHOM, BY WHOM, FOR WHOM?
For: Psychiatrists. Distinguished lecture series. Feb. 18. 8:00 PM. Chicago. **Speaker:** Robert Gibson, M.D. **CME Credit:** 1½ hrs. AMA Cat. 1. **Fee:** None. **Sponsor, contact:** Institute of Psychiatry-Northwestern U. Med. School, 320 E. Huron, Chicago 60611.

Sexual Dysfunction

HUMAN SEXUAL DYSFUNCTION
For: Mental Health Treatment Professionals. Symposium. Feb. 18. 1:00-4:00 PM. Forest Park. **Speaker:** Samuel Liber, M.D., Riveredge Hosp. **Fee:** $10. **Reg. Limit:** 204; reservations req. **Sponsor, contact:** Riveredge Hosp. Foundation, 8311 W. Roosevelt Rd., Forest Park, IL 60130.

Surgery and Medicine

SURGICAL AND MEDICAL TREATMENT OF THYROID DISEASE
For: All MDs. Symposium. Feb. 18. 2:00-5:00 PM. Glen Ellyn. **Speaker:** Leslie DeGroot, U of Chicago. **CME Credit:** 3 hrs. AMA Cat. 1; AAFP Elective. **Fee:** None. **Sponsor, contact:** DuPage County Medical Society, 646 Roosevelt Rd., Glen Ellyn, IL 60137.

March, 1976

Abdominal Surgery

HERNIA
For: Surgeons. 1 day post-garduate course. March 28, 9 AM-5 PM. Pick Congress Hotel, Chicago. **CME Credit:** 8 hrs. AMA Cat. 1. **Fee:** $40. **Sponsor, contact:** Amer. Society of Abdominal Surgeons, 675 Main St., Melrose, Mass. 02176. Attn: Blaise Alfano, M.D., Exec. Secy.

Asthma

ASTHMA IN 1976
For: Pediatricians. Monthly dinner meeting/lecture. March 16, 8:00 PM. Highland Park. **Contact, sponsor:** Chicago Pediatric Society, 2800 W. 87th St., Chicago 60652. Attn: Thomas Driscoll, MD (for dinner reservations).

Endocrinology

DISEASES OF THE ADRENALS
For: All MD's. Lecture. March 9. 8:00 PM. Highland Park. **Speaker:** Thomas Frawley, M.D., St. Louis Univ. Med. School. **Reg. Limit:** 70. **Reg. Deadline:** March 4. **Sponsor, contact:** Highland Park Hosp., 719 Glenview Ave., Highland Park, IL 60035. Attn: Mrs. Susan Struttle.

Family Medicine

BASIC INTERNAL MEDICINE
For: All MD's. 5 day course. March 15-19. **CME Credit:** 40 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 30. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612.

RECENT ADVANCES IN DIABETES
For: All MD's. Lecture. March 16. 8:00 PM. Sherman Hospital, Elgin. **Speaker:** Boyd Metzger, M.D., Northwestern Univ. School of Med. **CME Credit:** 2 hrs. AMA Cat. 1. **Sponsor, contact:** CME Committee of Sherman Hosp., 934 Center St., Elgin, IL 60120. Attn: Walter E. Gasser, M.D.

DIAGNOSIS AND MANAGEMENT OF PROBLEMS OF GYNECOLOGY
For: All MD's. 5 day course. March 22-26. **CME Credit:** 32½ hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Graduate School of Medicine. 707 S. Wood St., Chicago 60612.

General Surgery Trauma

CLINICAL HOSPITAL PROGRAM ON GENERAL SURGERY TRAUMA
For: All physicians, residents, interns. 2-hour evening clinical program. March 23. Harvey, IL. **CME Credit:** 2 hrs. AMA Cat. 1, AAFP. **Sponsor, contact:** Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. Attn: Mrs. Lillian Husa, Exec. Sec.

Internal Medicine

ONE WEEK COURSE IN BASIC INTERNAL MEDICINE
For: All MD's. 5 day course. March 15-19. **CME Credit:** 40 hrs. AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 50. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612.

Musculoskeletal Trauma

CLINICAL HOSPITAL PROGRAM ON MUSCULOSKELETAL TRAUMA
For: All MD's, residents, interns. 2-hour evening clinical program. March 16. Illinois Central Hosp., Chicago. **CME Credit:** 2 hrs. AMA Cat. 1, AAFP. **Sponsor, contact:** Chicago Committee on Trauma of the American College of Surgeons, 11255 W. 74th St., LaGrange, IL 60525. Attn: Mrs. Lillian Husa, Exec. Sec.

Neurology

NEUROLOGY, PART I, BASIC
For: All MD's. 5½ day course. March 15-20. **CME Credit:** 44 hrs. AMA Cat. 1. **Reg. Limit:** 80. **Fee:** $225. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612.

REVIEW COURSE IN NEUROPATHOLOGY
For: Neuropathologists. 5½ day course. March 22-27. **CME Credit:** 40 hrs. AMA Cat. 1. **Fee:** $225. **Reg. Limit:** 30. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612.

Neurotology

NEUROTOLOGY IN OTOLARYNGOLOGY
For: Neurotologists, Otolaryngologists, Audiologists. 4-day course. March 22-25. Chicago. **Speaker:** Nicholas Torok, M.D. **CME Credit:** 28 hrs. AMA Cat. 2. **Fee:** $300. **Reg. Limit:** 15. **Sponsor, contact:** Univ. of Ill., Dept. of Otolaryngology, 1855 W. Taylor St., Chicago 60612. Attn: Marion Wickland, Admin. Sec.

Occupational Medicine

CLINICAL PROBLEMS IN THE DIAGNOSIS AND TREATMENT OF OCCUPATIONAL LUNG DISEASE
For: All MD's. 2½ day lecture and workshop. March 15-17. Chicago. **Speaker:** Bertram Carnow, MD. **Fee:** $100 (ACCP Member), $125 (AACP Non-member). **Reg. Limit:** 125. **Reg. Deadline:** March 15. **Co-sponsor:** Chicago Lung Assoc., Univ. of Ill. School of Public Health. **Sponsor, contact:** Amer. College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068. Attn: Dale Braddy.

Patology

REVIEW COURSE IN NEUROPATHOLOGY
For: Neuropathologists. 5½ day course. March 22-27. **CME Credit:** 40 hrs. AMA Cat. 1. **Fee:** $225. **Reg. Limit:** 30. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612.

Pediatrics

ADVANCES IN PERINATOLOGY
For: Pediatricians. Lecture. March 10. 9:00 AM-5:00 PM. Chicago. **Speaker:** John Madden, M.D. **CME Credit:** 6 hrs. AMA Cat. 1, AAFP. **Fee:** $30. **Reg. Limit:** 250. **Sponsor, contact:** University of Chicago, Frontiers of Medicine, 950 E. 59th St., Chicago 60637.

Psychiatry

PSYCHIC HEALING: PITFALLS & POSSIBILITIES
For: Physicians and Mental Health Professionals. Lecture Series. March 3. 7:30 PM-9:30 PM. Des Plaines. **Speaker:** Stanley Krippner, Ph.D. **CME Credit:** 2 hrs. AMA Cat. 1, AAFP Elective. **Fee:** $90 (entire series); $15 (indiv. lectures). **Reg. Limit:** 120. **Co-sponsor:** Chicago Medical School, Dept. of Psychiatry. **Sponsor, contact:** Forest Hospital Foundation, 555 Wilson Lane, Des Plaines, IL 60016. Attn: June Bengsten.

THE FORMATIVE PROCESS: TOWARD A CHANGE IN THE PSYCHIATRIC PARADIGM
For: Psychiatrists. Distinguished lecture series. March 17. 8:00 PM. Chicago. **Speaker:** Robert Lifton, M.D., Yale University. **CME Credit:** 1½ hrs. AMA Cat. 1. **Sponsor, contact:** Institute of Psychiatry, Northwestern U. Med. School, 320 E. Huron St., Chicago 60611. Attn: Dr. Barbara Kay.

Psychotherapy

LITERARY PSYCHOTHERAPY: HAMLET, THE COUP THAT FAILED
For: Mental Health Treatment Professionals. Symposium. March 17. 1:00 PM-4:00 PM. Forest Park. **Speaker:** Natalie Shainess, M.D., Columbia Univ. **Fee:** $10. **Reg. Limit:** 204 (Reser. Req.) **Sponsor, contact:** Riveredge Hospital Foundation, 8311 W. Roosevelt Road, Forest Park, IL 60130. Attn: John Pontarelli, Community Relations Coord.

Urology

ADVANCES IN UROLOGY
For: Urologists. 2 day course. March 8-9. **CME Credit:** 16 hrs. AMA Cat. 1. **Fee:** $30. **Reg. Limit:** 25. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612.

NEWER UROLOGIC INSTRUMENTATION
For: Urologists. 1 day course. March 10. **CME Credit:** 8 hrs. AMA Cat. 1. **Fee:** $50. **Reg. Limit:** 8. **Sponsor, contact:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612.

PEDIARTIC UROLOGY
For: Pediatricians, Urologists. 2 day course. March 11-12. **CME Credit:** 16 hrs. AMA Cat. 1. **Fee:** $80. **Reg. Limit:** 25. **Sponsor, contact:** Cook County Grad. Sch. of Med., 707 S. Wood St., Chicago 60612.

Recent CME Accreditations

The ISMS Committee on CME Accreditation has recently approved the CME programs of these institutions:

Carle Foundation Hospital
Urbana
Central DuPage Hospital
Winfield
Chicago Read Mental Health Center
Chicago
FAB³ CME
Chicago
Lutheran General Hospital
Park Ridge
Manteno State Hospital
Manteno
The Methodist Medical Center of Illinois
Peoria
North Shore Mental Health Association/Irene Josselyn Clinic
Northfield
Skokie Valley Community Hospital
Skokie

Utilization and Referral Patterns in the Acute Illness Department of a Multispecialty Clinic

By Frank Jones, M.D., and Carol Kruger/Urbana

In a previous article[1] Dr. Pollard outlined the way Carle Clinic resolved one of the big problems of large multispecialty clinics—that of acutely ill patients who cannot wait for scheduled appointments. The development of acute Illness Department handling both walk-in patients and emergencies was discussed. Eighteen months later the Acute Illness Department operation was reassessed.

The purpose of this study was to analyze utilization and referral patterns of the Acute Illness Department (AID) in order to: (1) assess the quality and quantity of medical care given, (2) determine the impact of a newly created Family Practice Department (FPD) within the clinic on the AID, (3) determine how the efficiency of the AID could be improved by the utilization of nurse practitioners, and (4) determine if a rural satellite clinic would be practical in terms of patient load.

Operation of AID

The AID includes a walk-in general practice clinic and an adjoining emergency room within a large multispecialty clinic and 225 bed hospital complex. It is located in a community of 100,000 served also by three other hospitals and one other large multispecialty clinic. The clinic also acts as a regional referral center. The "trauma center" for the community is located at another hospital so the emergency room of the AID sees few cases of multiple trauma (eg. auto accidents, gunshot and stab wounds). In the past two years, there have been approximately 35,000 patient visits per year to the AID.

The AID is currently staffed by four full-time and several part-time physicians with coverage 24 hours, 7 days a week. The AID staff also includes 8 registered nurses, 4 licensed practical nurses, 1 technician, 3 orderlies and 7 secretaries.

Recently nurses have been instructed in suturing techniques and now handle most of the minor suturing in the AID with the exception of facial lacerations. This has enabled the physicians to be more productive and efficient. It has been proposed that one or more nurses receive additional training as nurse practitioners. Nurse practitioners could make the initial triage decisions and treat most upper respiratory infections according to a standardized protocol. However, an analysis of patient visits to the AID was needed first to determine the feasibility of this planned operation.

In January, 1974, a Family Practice Department (FPD) was started within the clinic. There were mixed feelings about the impact this new department would have on the AID in terms of utilization and referral patterns. Thus, it was of great interest to analyze patient visit patterns before and after the creation of the FPD.

It has also been proposed that the clinic establish one or more satellite clinics to provide primary care in areas where there are few or no local physicians and access to the main clinic is difficult. In this regard it was of interest to determine the geographical pattern of patient visits to the AID.

Methods

Information for utilization and referral patterns was taken from existing AID logs and patients' medical charts. In addition, during a one month period physicians were asked to record the time they saw a patient on the patient's charge slip. This was done in order to calculate waiting times. Records were analyzed over a six month period beginning in January, 1974.



FRANK S. JONES, M.D., is in General and Preventive Medicine at the Carle Clinic, Urbana. He practices in the Acute Illness Department and is affiliated with Carle Foundation Hospital. Dr. Jones is a member of several professional societies as well as Alpha Omega Alpha and Delta Omega, a public health honorary. He has received the AMA Physician's Recognition Award each year since 1973.

CAROL KRUGER is the Clerical Supervisor at Carle Hospital.

Results

The average number of patient visits per day was 106. The peak patient arrival time was between 9:00 A.M. and 11:00 A.M. when there were up to 11 visits per hour. The longest average waiting time for non-emergency patients was two hours, occurring at midday. Patient visits and waiting times decreased proportionately reaching a minimum between 2:00 A.M. and 6:00 A.M.

Geographically, 72% of visits of the AID occurred among residents of Champaign-Urbana; 18% among residents outside Champaign-Urbana, but within a 25 mile radius of the hospital; 7% among residents between 25 and 50 miles from the hospital; and 3% among residents living over 50 miles from the hospital. The Eastern quadrant, which includes Danville, accounted for half of the visits in the 25-50 miles radius group.

Visits were grouped according to medical priority.[2] Emergency visits included all those life-threatening situations requiring immediate care and hospitalization such as myocardial infarction, gastrointestinal hemorrhage and severe trauma. Priority visits were defined as all cases requiring definite evaluation and treatment within a matter of hours. These patients were placed in the observation or trauma room. Routine visits included all patients with chronic or minor acute ailments who were judged well enough to wait their turn in the examining rooms. Routine visits were divided into upper respiratory infections (URI's) and other. As can be seen from Table I and Fig. 1, emergency visits accounted for only a tiny fraction of the AID patient load. Over two-thirds of the visits were classified as routine, and nearly one-third of these routine visits were URI's. The percentage of visits due to URI's peaked at 25% in February and reached a low of 14% in June. There was no noticeable seasonal trend observed for the other categories.

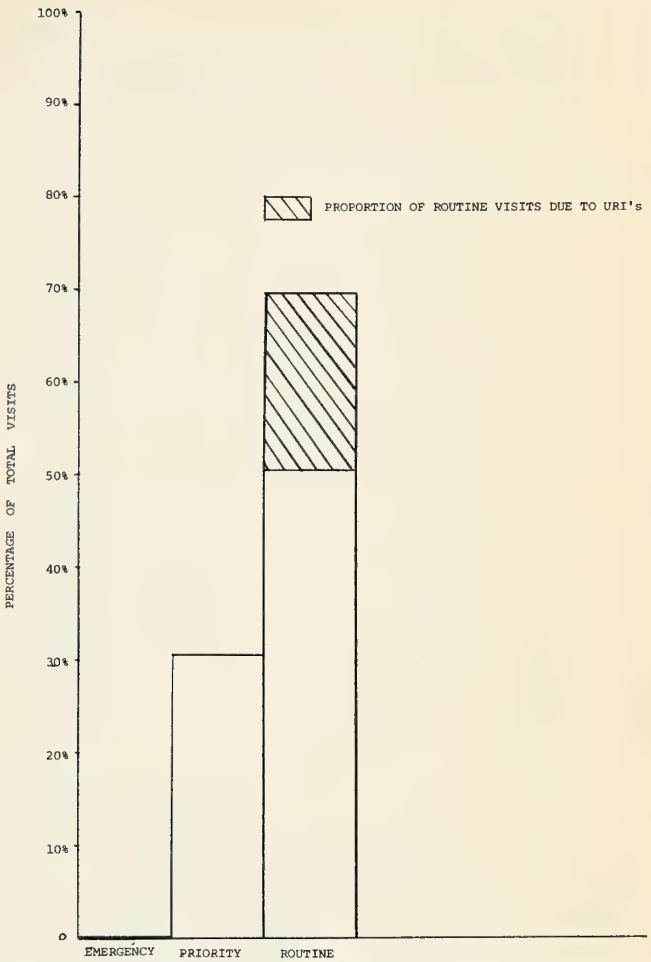


Figure 1. Classification of ER-AID patient visits Jan.-June, 1974. Average number seen—3075/month.

The average number of visits per day ranged 87 in January to 110 in April with a six month average of 101 visits per day.

Patterns of Referral and Admission

Patterns of referral and admission from the AID are as follows.** Eighty-nine percent of all

Table I
AID-ER Visits by Month and Priority

Type of Visit*	Jan. (% of 2697 total visits)	Feb. (% of 2888 total visits)	Mar. (% of 3166 total visits)	Apr. (% of 3316 total visits)	May (% of 3262 total visits)	June (% of 3129 total visits)	1st 6 mos 1974 (% of 18,458 total visits)
Emergency	0.4%	0.3%	0.1%	0.1%	0.2%	0.1%	0.2% (35)
Priority	29.5%	27.2%	30.1%	30.1%	32.8%	32.6%	30.5% (5623)
Routine, URI	20.5%	25.0%	22.7%	18.5%	15.5%	14.1%	19.3% (3554)
Routine, Other	49.5%	47.5%	47.0%	51.3%	51.5%	53.1%	50.1% (9246)

**Definitions given in the text of the report.*

***Referrals include all patients with referral slips filled out by the AID physician.*

patient visits were evaluated, treated and discharged. Of the remaining 11%, one-third were given semi-urgent or routine referrals to specialty clinics, mostly internal medicine and orthopedics (see Table 2 and Fig. 2). Note that the percentage of semi-urgent and routine referrals going to the Family Practice Department increased from zero in December to 7% in March and later leveled off to 5%. Of all the specialty clinics, the highest number of referrals went to orthopedics (25%) and internal medicine (20%). This pattern of referral did not show any significant seasonal change nor did it appear to be affected significantly by referrals to the Family Practice Department.

Eight percent of all visits required immediate (same day) referrals (Table 2 and Fig. 3). Nearly half of these were seen by internists who admitted 80% of them to the hospital. The next largest segment, about 10%, were seen by orthopedic surgeons. The percentage of immediate referrals now handled by the Family Practice Department varies quite a bit, but averages 3%.

Discussion

The distribution of patient visits (and waiting time) by time of day was expected, based on the AID-ER physician coverage at that time. The peak number of visits occurred in mid morning with a smaller peak after the supper hour. Maximum waiting time occurred among those signing in around noon and gradually tapered off during the afternoon.

In the past, Mondays had the heaviest patient load of the week and Sundays the lightest. The other days were about equal in terms of average patient visits per 24 hours. Accordingly three AID-ER physicians were assigned to day shifts on Monday, two physicians on Tuesday through Saturday and one physician on Sunday. Another physician to cover the peak day time hours (10 A.M. to 2 P.M.) Monday through Saturday would have been desirable, but additional physician manpower was not available at that time. It was felt a nurse practitioner could handle from 15% to 25% of this patient load depending

Table II
Distribution of Referrals from the AID-ER to Other Specialty Clinics by Urgency of the Referral

Semi-Urgent and Routine Referrals	January	February	March	April	May	June	1st 6 Mos 1974
% referred of total AID-ER visits	3.4% (93) *	2.9% (83)	2.6% (83)	3.5% (115)	3.3% (108)	4.0% (124)	3.3% (606)
% Family Practice referrals of total referred	3.2%	7.2%	6.0%	5.2%	6.5%	4.8%	
% Int. Med. referrals of total referred	12.9%	18.1%	24.1%	17.4%	23.1%	20.2%	
% Orthopedic referrals of total referred	37.6%	16.9%	25.3%	24.3%	29.6%	25.8%	
Same Day Referrals							
% referred of total AID-ER visits	8.7% (234) *	6.8% (197)	8.1% (258)	9.5% (316)	7.9% (259)	7.7% (241)	8.1% (1505)
% Family Practice referrals of total referred	1.7%	3.0%	3.1%	7.6%	1.2%	3.7%	
% Int. Med. referrals of total referred	43.2% (84%)†	47.0% (87%)	47.7% (76%)	42.4% (70%)	47.1% (80%)	46.1% (82%)	
% Orthopedic referrals of total referred	10.7% (64%)†	10.0% (63%)	10.1% (46%)	12.7% (63%)	7.7% (65%)	10.0% (54%)	

**Total number referred.*
†% referred that are admitted to the hospital that day.

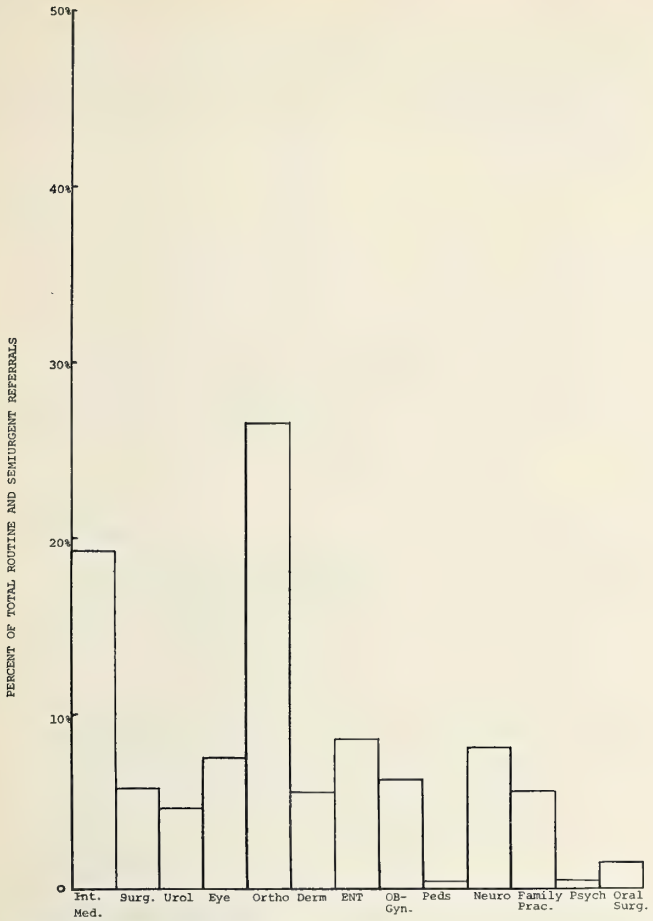


Figure 2. ER-AID referrals, routine and semiurgent, Jan.-June, 1974. Percent of total routine and semiurgent referrals.

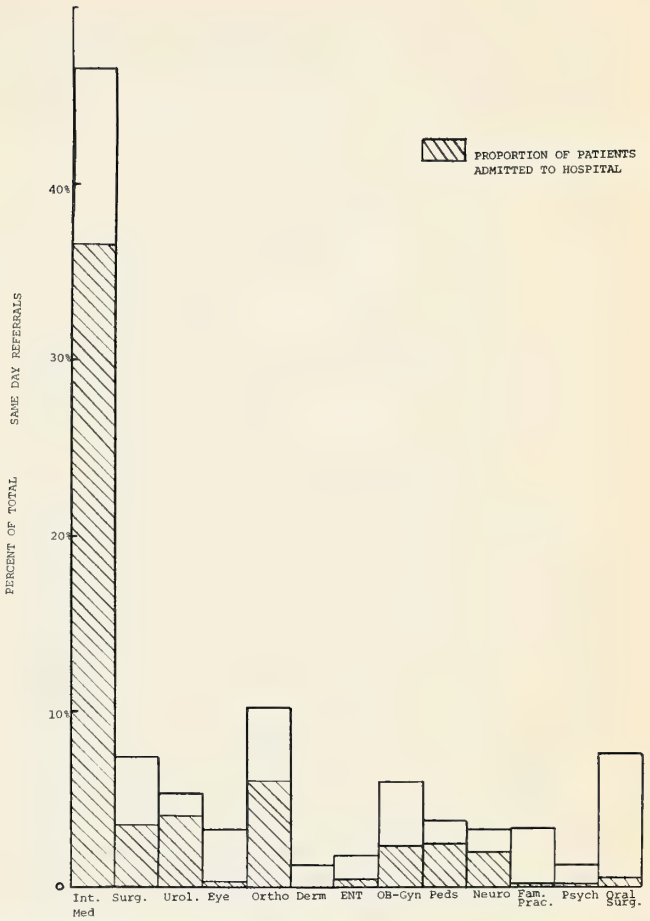


Figure 3. ER-AID same day referrals, Jan.-June, 1974. Percent of same day referrals.

on season of the year. (This will be discussed in a later section).

One AID-ER physician was assigned to the evening shift, and one physician covered the night shift. In order to help the evening physician with the after-supper peak, day shifts were staggered and lengthened to overlap the evening shift. As long as the evening and night shifts didn't have to be combined because of personnel shortages, this arrangement worked quite well.

Geographical Summary

The geographical distribution of visits to the AID showed that over a quarter of the visits were from people living outside Champaign-Urbana. Two-thirds of these non Champaign-Urbana residents lived within a 25 miles radius of the clinic. This appears to support the idea of satellite clinics. A base of approximately 6,650 patient visits per year would be expected for these clinics, which could lower the current AID patient load by 20%. The patient load from these areas is expected to increase in the future for two reasons: 1) the retirement of older general practitioners and 2) the phasing out of nearby Chanute Air Force Base's primary medical care facility for military dependents.

The geographical distribution of patient visits to the AID was quite different from that of the clinic and hospital. This discrepancy was largely due to the fact that the distribution for the AID was based on visits while those of the clinic and hospital were based on patients. We conjectured that people living close to the clinic were likely to make more visits. Also, the clinic and hospital distributions were last calculated in 1972. The difference reflected the fact that the AID saw many local people frequently that were not regular clinic or hospital patients.

Type of Visits

As expected true emergencies constituted only a tiny fraction of total visits to the AID. Even though the definition of "emergency" may have been somewhat restrictive, it was clear that the main function of the AID was to render primary care. Priority visits accounted for 30% of the total patient load. These consisted mainly of minor injuries (sprains, strains, lacerations, bites, simple fractures, etc.) Seventy percent of the visits were considered routine and comprised a variety of acute and chronic illnesses which would typically have been seen in a general practice setting. Upper respiratory infections accounted for 14% to 25% of the total visits depending on the season of the year. This was a significant portion of the total patient load. A nurse practitioner could easily triage and treat patients in this group, under physician supervision. Since most URI's come to the AID during the day, this could reduce the physician work load considerably during peak hours and hopefully reduce waiting times.

Only 11% of total AID visits were referred to specialists (an average of 12 per day). Over two-thirds of these were immediate (same day) referrals. The majority of immediate referrals were admitted to the hospital (an average of 5 admissions per day). Thus, the percentage of referrals appears to be fairly low especially when the fact is taken into account that a considerable number of people come to the AID because they can't be seen in the specialty clinics as soon as they would like or because they want to be admitted to the hospital.

Internal Medicine and Orthopedics consistently had the largest number of referrals from the AID. Most of the Internal Medicine referrals were immediate and 80% of these were admitted to the hospital—such as myocardial infarctions and strokes. Most of the Orthopedic referrals were semi-urgent or routine and consisted largely of follow-up visits for fractures, serve sprains, and low back strains—particularly of a work-related nature.

Under 10% of the referrals were made to the newly formed Family Practice Department. This was partially due to the fact that the FPD was not yet fully staffed, but it also reflected the fact that there was a little overlap between the services offered by the AID and FPD. As stated previously, the existence of the Family Practice Department had had no significant effect on patterns of referral from the AID to other specialty clinics, nor had it had any noticeable effect on the patient load in the AID.

Conclusions

(1) A nurse practitioner would increase the efficiency of the AID by initially screening upper respiratory infections—15% to 25% of the patient load. This would free up physician time, particularly during the peak patient load at midday and would hopefully reduce waiting times.

(2) Primary care satellite clinics would appear to fill a need for patients residing within a 25 mile radius of the clinic. They could also lower the current AID patient load by as much as 20%.

(3) The creation of the Family Practice Department (FPD) at Carle Clinic has not significantly altered the AID utilization and referral patterns as yet. However, the FPD is currently operating with just one full-time physician.

(4) Seventy percent of the patient visits to the AID are of a "routine" nature. Despite the fact that a considerable proportion of all AID visits results from patients who feel they cannot wait for a regular clinic appointment, 89% of total visits are handled entirely within the AID system.

Addendum, July 1975

A nurse practitioner system with detailed health care protocols has recently been instituted in the AID. A second study of the AID will be undertaken from January to July 1976 to evaluate this system. Also, a satellite clinic, currently limited to pediatrics, is now operating successfully in Mahomet (about 15 miles from the main clinic). ◄

References

1. Pollard, J. W. "Carle Meets the Problem of Immediate Care", *Group Practice* pp 39-40. July, 1972.
2. Rosen, P. Segal M., Coppleson, L. and Fauman, B. "A Method of Triage Within an Emergency Department", *Journal of the American College of Emergency Physicians,* 3:85-86, March-April, 1974.

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

AURORA—Board eligible or certified gynecologist to join established corporation in town of 75,000—30 miles west of Chicago. Guaranteed salary 1st year with partnership arrangements thereafter. Option to buy in anytime. G. J. Shimkus, M.D., 143 So. Lincoln Ave., Aurora, 60505. 312-896-7892, (5)

CHICAGO: Take over large general practice. No investment required. Modern, fully equipped and staffed facility. Salary and Profit Sharing yields. Contact: M. Beederman, Suite 300, 2400 E. Devon, Des Plaines 60018. 312-298-3500 (2)

CHICAGO: Medical Center N.W. Side of Chicago with clinical laboratory, X-rays, physical therapy. 2 Family Physicians, members A.A.P.F., looking for a young, well trained, ambitious F.P. Privileges in hospital with Department of Family Practice, F. S. Steinitz, M.D., 3653 W. Lawrence, Chgo. 60625 (312-478-6000). (4)

CHICAGO: Physician needed for well established, ultra modern medical center. Full laboratory and X-ray. Congenial working conditions and excellent co-workers. Good hospital associations. No evenings or weekends. Clinic located south side, near lake. Contact Mr. Lawrence, Booker Family Health Care Center, 747 E. 47th, Chicago, 60653, (312) 624-4800. (1)

CHICAGO: Physician wanted for busy practice Uptown area of Chicago. No night call. Financial arrangements and hours flexible. Excellent opportunity. Partnership available if desired. Contact: P. Riordan, M.D., Berwyn Medical Center, 1185 W. Berwyn, Chicago 60640, (312) 334-7260.

CHICAGO: Urban area. Desire physicians interested in General Medicine to work with indigent population. Hospital based. Financial assistance available. Contact M. Shulman, 426 W. Wisconsin, Chicago 60614, (312) 751-4000. (4)

DIXON: Internist-Pediatrician-Orthopedic Surgeon-board certified/board eligible. Well established multi-specialty clinic, closely affiliated with a 200 bed hospital, offers opportunities to build a large practice in these specialties. Progressive community, within ninety miles of Chicago, offers a unique family oriented environment. No traffic problems, clean air, and excellent recreation areas combine to provide the "good life." Only 45 minutes from Rockford, allows easy access and exposure to academic medicine. Phone collect—John Tatum, Administrator, Medical Arts Clinic, Dixon, 61021. (815) 288-5531. (3)

ELK GROVE VILLAGE: Two physicians in busy growing suburban Chicago practice of Family and Industrial Medicine, are seeking a third. Unlimited opportunity in either area with liberal vacation schedule. Office in building connected to hospital for convenience and efficiency. Unusual opportunity. Contact: John A. Medved, M.D., 850 W. Biesterfield Road, Elk Grove Village 60007, 312-437-0600 (4)

ELMHURST: Woman Resident in medicine needed when residency finished by two internists and one family practitioner, all young women, having joint practice in western suburb of Chicago. Exceptionally advantageous situation for woman doctor interested in practicing general medicine. Contact: Dr. Charlotte M. Blain, 135 Cottage Hill, Elmhurst 60126. (312) 832-6633. (4)

FRANKFORT: Young generalist and Ob-Gyn wanted for nine man group located 30 miles S.W. Chicago; approved profit sharing plan and incentive plan. Contact: Howard Osmus, Administrator, Hedges Clinic, Frankfort, 60423. 815-469-2123 (4)

HARDIN: Doctor wanted to work in modern three doctor medical center presently staffed with one doctor. Laboratory and x-ray equipment available. New ambulance which is manned by 50 trained EMTA volunteers. Hospital nearby. Located in beautiful Calhoun County Illinois between the Mississippi and Illinois rivers within one hour drive of St. Louis. Excellent hunting and fishing facilities. Contact: Calhoun County Farm Bureau, Hardin, Illinois 62047. Phone 618-576-2233. (3)

HARVEY: Pleasant moderate-sized general practice with full lab, expert clerical staff and list of consultants in Chicago south suburbs with modern hospital nearby. Full or part-time M.D.'s desired. Competitive salary negotiable, with benefits, flexible schedule and other valuable considerations, as office is expanding. Good opportunity for right doctors. Contact: Mrs. Wynne, 14734 Oakley, Harvey, (312) 331-8000 (3)

KANKAKEE: Emergency Room Physician, Board eligible or certified preferred, needed for 300 bed acute care hospital in Chicago area. Liberal fringe benefits. Contact Raymond Malott, M.D., St. Mary's Hospital, 500 West Court Street, Kankakee 60901. Phone (815) 939-4111. (3)

McHENRY: Immediate openings for General Internist, Cardiologist, Cardio-Vascular and Thoracic Surgeon, Urologist and Orthopedic Surgeon. Outstanding opportunity to join multi-specialty group in mid-west resort area near Chicago. Salary with incentive from day one: fringe benefits and unusually good income potential. Group building directly connected to 143 bed community hospital. Contact: Ted L. Rolander, M.D., McHenry Medical Group, 1110 N. Green St., McHenry 60050 or (815-385-1050) (3)

NASHVILLE: Population 3,000—serving area 14,000 plus. Board certified or eligible General Surgeon willing to do general practice, Solo or Associate. 72 bed JCAH Hospital. 50 miles east of St. Louis, Mo. Contact: T. K. Janssen 618-327-8236, 603 S. Grand, Nashville 62263. (3)

WHEATON: Family practitioners wanted. 6 man F.P. Group seeking additional F.P.'s. Excellent salary and fringes, early partnership, beautiful community, 30 minutes from Chicago, great opportunity. Contact: G. Wesley Farah, Wheaton Medical Clinic, Ltd., 1530 North Main St., Wheaton, IL 60187. (312) 665-6200. (4)

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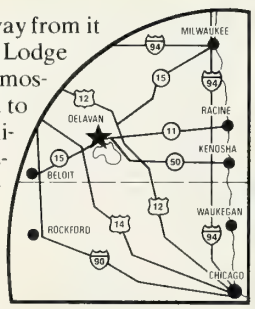
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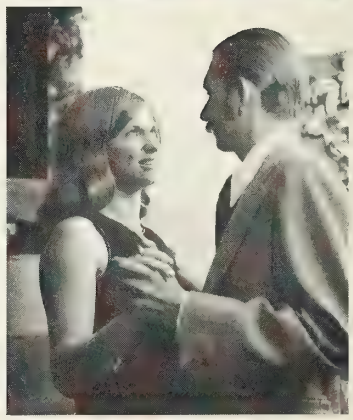
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